

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy

Schyma, Jan (2010) *An Investigation Into The Effectiveness Of Homeopathy In Improving Perceived Well Being And Quality Of Life In The 55+ Age Group*. PhD thesis, Queen Margaret University.

Accessed from:

<http://etheses.qmu.ac.uk/570>

### **Repository Use Policy**

The full-text may be used and/or reproduced, and given to third parties for personal research or study, educational or not-for-profit purposes providing that:

- The full-text is not changed in any way
- A full bibliographic reference is made
- A hyperlink is given to the original metadata page in eResearch

eResearch policies on access and re-use can be viewed on our Policies page:  
<http://eresearch.qmu.ac.uk/policies.html>

<http://etheses.qmu.ac.uk>

AN INVESTIGATION INTO THE EFFECTIVENESS OF HOMEOPATHY IN  
IMPROVING PERCEIVED WELL BEING AND QUALITY OF LIFE IN THE  
55+ AGE GROUP

JAN SCHYMA

A thesis submitted in partial fulfillment of the requirements for the degree of Doctor of  
Philosophy

QUEEN MARGARET UNIVERSITY

2010

i

---

## Abstract

The purpose of this study is to investigate the effectiveness of homeopathy in improving perceived health and well being in the 55+ age group. Homeopathy is defined as a complex intervention including the homeopathic remedy, the therapeutic relationship and participant choices about self care. The literature on health care for the 55+ age group suggests growing concern about the need to find ways of improving the health and quality of life of older people. Smallwood (2005) suggests that homeopathy and Complementary and Alternative Medicine (CAM) may contribute to improvement in the health and well being of older people in our society. Research has been carried out into the use of homeopathy to improve health and well being, but has not focused on homeopathy as a complex intervention or its use for the 55+ age group.

A mixed methodology was chosen for this research study based on a pragmatic approach. An embedded design was used, with qualitative measures as the primary source of data and quantitative measures as the secondary source. Twenty participants were recruited and received homeopathic treatment. Their response to treatment was recorded in interview transcripts, case notes, the practitioner's reflective journal, and results from Measure Your Own Medical Outcomes Profile (MYMOP) and SF-36 questionnaires. The practitioner was also the researcher.

The participants in this study clearly identified the outcomes and the nature of the experience. 18 out of 20 participants noted a definite or limited improvement in their health which they associated with homeopathic treatment. Additionally, participants valued the opportunity to review life experiences, to make connections between life events and health issues and the resulting increase in self awareness. They reported benefits that were consistent with classical homeopathic philosophy and practice, and other research studies into homeopathic treatment. Their evidence confirmed that homeopathy provided a healing experience both physically and emotionally which met the complex needs of participants in the study, and potentially future health care needs of this age group.



## Acknowledgements

Sincere thanks go to all those who have provided support for this research project, most importantly the participants who shared their stories and their viewpoints so willingly. Dr Mary Warnock and Professor Marie Donaghy, director of studies and supervisor, were patient and generous in giving their time and expertise. Thanks also to all family and friends who offered encouragement and support along the way.

v

---

## Contents

<b>Abstract</b>	<b>ii</b>
<b>Acknowledgements</b>	<b>iv</b>
<b>Figures</b>	<b>12</b>
<b>Tables</b>	<b>14</b>
<b>INTRODUCTION</b>	<b>16</b>
<b>CHAPTER 1: LITERATURE REVIEW</b>	<b>20</b>
<i>1.1 AN AGEING POPULATION</i>	22
1.1.1 Health problems commonly experienced in the 55+ age group	23
1.1.2 The cost of health problems in the 55+ age group	26
<i>1.2 FACTORS WHICH IMPACT ON HEALTH AND HEALING</i>	29
1.2.1 What is health?	29
1.2.2 Beliefs about health, illness and ageing	30
1.2.3 The therapeutic relationship and the patient's story	36
1.2.4 The placebo effect	38
1.2.5 The impact of stress on health	41
1.2.6 Self care	42
<i>1.3 HOMEOPATHY</i>	44
1.3.1 The history of homeopathy	44
1.3.2 Aims of homeopathic treatment	50
1.3.3 Theory and philosophy of homeopathy	51
1.3.4 The homeopathic remedy	53
1.3.5 The homeopathic interview	56
1.3.6 Remedy reactions	59
1.3.7 Homeopathy in the UK	61
1.3.8 Homeopathy worldwide	63
1.3.9 The debate about homeopathy	64
<i>1.4 RESEARCH PERSPECTIVES ON HOMEOPATHY</i>	70
1.4.1 Evidence based medicine and homeopathy	70
1.4.2 Research into the action of the homeopathic remedy	73



1.4.3	Research studies of homeopathy and CAM	77
1.4.4	Current research methods for evaluating homeopathy	87
1.4.5	Researching homeopathy as a complex intervention	89
<b>CHAPTER 2:</b>	<b>METHODOLOGY</b>	<b>92</b>
2.1	<i>INTRODUCTION</i>	92
2.2	<i>PHILOSOPHICAL ASSUMPTIONS FOR THIS STUDY</i>	93
2.3	<i>DESIGN OF RESEARCH STUDY</i>	97
2.4	<i>TRUSTWORTHINESS OF RESEARCH DATA</i>	99
2.4.1	The aims of the study	99
2.4.2	The chosen methodology	99
2.4.3	The practice of homeopathy	100
2.4.4	Supervision of the research process	100
2.4.5	Analysis of data	101
2.4.6	Validity of research methods	101
2.4.7	Reliability of research methods	105
2.4.8	Reflexivity	106
2.5	<i>RESEARCH METHODS</i>	109
2.5.1	Qualitative methods	109
2.5.2	Quantitative methods	124
2.5.3	Recruitment of participants	129
2.5.4	Management of homeopathic treatment process	137
2.5.5	Analysis of research data	140
<b>CHAPTER 3:</b>	<b>RESULTS</b>	<b>144</b>
3.1	<i>INTRODUCTION</i>	144
3.2	<i>DEMOGRAPHIC INFORMATION ABOUT PARTICIPANTS</i>	145
3.3	<i>INTERVIEWS WITH PARTICIPANTS</i>	146
3.3.1	Perceived outcomes of treatment	148
3.3.2	The therapeutic relationship	152
3.3.3	Beliefs about health and homeopathic treatment	159
3.3.4	Aspects of the treatment process that were valued by participants	166
3.3.5	Summary of selected outcomes from participant interviews	172
3.4	<i>CASE NOTES OF PARTICIPANTS</i>	174

3.4.1	The homeopathic analysis of participant case notes	175
3.4.2	Remedy reactions	180
3.4.3	Patient beliefs about homeopathy and changes in their health	183
3.4.4	Participants' symptoms and treatment	184
3.4.5	Summary of outcomes including participant case notes	196
3.5	<i>PRACTITIONER REFLECTIONS</i>	198
3.5.1	The outcomes of treatment	199
3.5.2	The process of treatment	202
3.5.3	The role of caring professional	205
3.5.4	The role of independent researcher	207
3.5.5	Insights provided by the reflective journal	208
3.5.6	Summary of outcomes including homeopath's perspective	210
3.6	<i>DATA GATHERED FROM MYMOP QUESTIONNAIRES</i>	212
3.6.1	Selection of symptoms and activities	213
3.6.2	Summary of responses to MYMOP questionnaires	215
3.6.3	Comparisons for MYMOP data over time and for individuals	217
3.6.4	Duration of symptoms	223
3.6.5	Analysis of responses to questions on medication	224
3.6.6	Statistical analysis of MYMOP data	225
3.6.7	Summary of outcomes including MYMOP questionnaire	227
3.7	<i>DATA GATHERED FROM SF-36 QUESTIONNAIRES</i>	229
3.7.1	Composite scores for all responses to SF-36 questionnaire	230
3.7.2	Scores for individual questions in the SF-36 questionnaire	242
3.7.3	Summary of outcomes including SF-36 questionnaire	248
3.8	<i>OUTCOMES OF TREATMENT FOR INDIVIDUALS</i>	250
3.8.1	Perceived outcomes of treatment	251
3.8.2	The therapeutic relationship	251
3.8.3	Beliefs about health and homeopathy	252
3.8.4	Aspects of the treatment process valued by participants	252
<b>CHAPTER 4: DISCUSSION</b>		<b>260</b>
4.1	<i>INTRODUCTION</i>	260
4.2	<i>OUTCOMES OF HOMEOPATHIC TREATMENT IN THIS STUDY</i>	261
4.2.1	Outcomes compared with other studies of homeopathy	262
4.2.2	Outcomes measured in homeopathic terms	266

4.2.3	Outcomes and the homeopathic process	271
4.3	<i>COMMON THEMES IN THIS STUDY</i>	274
4.3.1	Health care needs of the 55+ age group and the study cohort	274
4.3.2	Causation of health problems in the 55+ age group and the study cohort	279
4.3.3	The principles and process of homeopathic treatment	282
4.3.4	Participant experiences of taking the homeopathic remedy	287
4.3.5	Participant beliefs about the therapeutic relationship	292
4.3.6	Participant beliefs about homeopathy, health and healing	295
4.3.7	Interpretation of thematic evidence	298
4.4	<i>CHOSEN RESEARCH METHODOLOGY FOR THIS STUDY</i>	300
4.4.1	The research questions	300
4.4.2	Mixed methodology	301
4.4.3	Qualitative data	302
4.4.4	Quantitative data	304
4.4.5	The role of homeopath and researcher	307
4.4.6	Reflexivity	308
4.4.7	Evaluation of the research methodology	312
<b>CHAPTER 5:</b>	<b>CONCLUSIONS</b>	<b>318</b>
5.1	<i>OUTCOMES OF HOMEOPATHIC TREATMENT</i>	319
5.2	<i>COMMON THEMES IN RESEARCH EVIDENCE</i>	322
5.3	<i>CHOSEN RESEARCH METHODOLOGY</i>	324
5.4	<i>RESEARCH INTO THE EFFECTIVENESS OF HOMEOPATHY</i>	325
<b>REFERENCES</b>		<b>328</b>
<b>APPENDICES</b>		<b>356</b>
<b>Appendix 1: Proving homeopathic remedies</b>		<b>358</b>
<b>Appendix 2: Analysing symptoms using computer software</b>		<b>360</b>
<b>Appendix 3: Extract from Materia Medica</b>		<b>361</b>
<b>Appendix 4: Participant interview questions</b>		<b>362</b>
<b>Appendix 5: Ethical approval for study</b>		<b>366</b>

<b>Appendix 6: Information about homeopathy for participants</b>	<b>367</b>
<b>Appendix 7: Participant consent form</b>	<b>370</b>
<b>Appendix 8: Introduction to homeopathic consultations</b>	<b>371</b>
<b>Appendix 9: Illustration of analysis of interview questions</b>	<b>374</b>
<b>Appendix 10: Dates of appointments attended by participants</b>	<b>375</b>
<b>Appendix 11: Remedies prescribed to participants</b>	<b>376</b>
<b>Appendix 12: Common themes and participant experiences</b>	<b>377</b>
<b>Appendix 13: Unexpected outcomes of homeopathic experience</b>	<b>380</b>
<b>Appendix 14: Measure Your Own Medical Profile (MYMOP)</b>	<b>381</b>
<b>Appendix 15: SF-36 questionnaire</b>	<b>385</b>
<b>Appendix 16: An overview of positive homeopathy research</b>	<b>387</b>
<b>Appendix 17: Examples of Crosstabulation and Chi-Square tests for SF-36 data</b>	<b>395</b>



## Figures

Figure 1: Road sign indicating elderly people crossing the road .....	34
Figure 2: Samuel Hahnemann (1755 – 1843) .....	44
Figure 3: Hahnemann Hospital Liverpool 1910 (Wellcome Library, London) .....	47
Figure 4: A laboratory for making homeopathic remedies 1910 (Wellcome Library, London) .....	54
Figure 5: The London Homeopathic Hospital 1858 (Google Images 2009) .....	62
Figure 6: Cartoon mocking diluted homeopathic remedies ( <a href="http://www.ntskeptics.org/cartoons/weekly">www.ntskeptics.org/cartoons/weekly</a> ) ....	76
Figure 7: Comparison of scores for symptom 1 for first and fourth appointment.....	217
Figure 8: Comparison of scores for symptom 2 for first and fourth appointment.....	219
Figure 9: Scores for ability to carry out chosen activity at the first and fourth appointment.....	220
Figure 10: MYMOP well being scores for participants at the first and fourth appointment.....	221
Figure 11: Comparison of MYMOP well being scores for all appointments .....	222
Figure 12: SF-36 scores for participants' responses to questions on physical functioning .....	231
Figure 13: SF-36 scores for participants' responses to questions on role physical .....	232
Figure 14: SF-36 scores for participants' responses to questions on bodily pain .....	233
Figure 15: SF-36 scores for participants' responses to questions on general health .....	235
Figure 16: SF-36 scores for participants' responses to questions on vitality .....	236
Figure 17: SF-36 scores for participants' responses to questions on social functioning .....	237
Figure 18: SF-36 scores for participants' responses to questions on role emotional.....	238
Figure 19: SF-36 scores for participants' responses to questions on mental health .....	239
Figure 20: SF-36 scores for participants' physical component summary.....	240
Figure 21: SF-36 scores for participants' mental component summary .....	241
Figure 22: Responses to question 1 of the SF-36 questionnaire at the first and final appointment .....	243
Figure 23: Responses to question 3f of the SF-36 questionnaire at the first and final appointment .....	244
Figure 24: Responses to question 9e of the SF-36 questionnaire at the first and final appointment ....	245
Figure 25: Responses to question 9f of the SF-36 questionnaire at the first and final appointment .....	246



## Tables

Table 1: Terms used for literature search .....	21
Table 2: Summary of tasks and processes involved in analysis of participant case notes .....	121
Table 3: Themes and sub-themes revealed in participant interviews .....	147
Table 4: P1-10, summary of selected outcomes from participant interviews .....	172
Table 5: P11-20, summary of selected outcomes from participant interviews .....	173
Table 6: Response to homeopathic remedy .....	180
Table 7: Surprising reactions to homeopathic remedy identified by participants .....	182
Table 8: Summary of participants' physical symptoms .....	185
Table 9: Summary of participants' emotional symptoms .....	187
Table 10: Exciting and maintaining causes of emotional symptoms .....	190
Table 11: P1-10, summary of selected outcomes from participant case notes .....	196
Table 12: P11-20, summary of selected outcomes from participant case notes .....	197
Table 13: P1-10, summary of selected outcomes from the homeopath's perspective .....	210
Table 14: P11-20, summary of selected outcomes from the homeopath's perspective .....	211
Table 15: Summary of responses to MYMOP questions on symptoms and well being .....	215
Table 16: Duration of symptoms for participants in study .....	223
Table 17: Participant responses on the importance of cutting down or avoiding medication .....	225
Table 18: P1-10, summary of selected outcomes from the MYMOP questionnaire .....	227
Table 19: P11-20, summary of selected outcomes from the MYMOP questionnaire .....	228
Table 20: P1-10, summary of selected outcomes from the SF-36 questionnaire .....	248
Table 21: P11-20, summary of selected outcomes from the SF-36 questionnaire .....	249
Table 22: Categories of outcomes for homeopathic treatment .....	250
Table 23: Chappell's ten signs of homeopathic cure (1994) .....	268





## INTRODUCTION

The purpose of this study is to evaluate the therapeutic use of homeopathy as an alternative or complementary method of treating health problems in the 55+ age group.

The literature on health care for the 55+ age group suggests growing concern about the need to find ways of improving the health and quality of life of older people. Major concerns have been expressed about the health related issues of an ageing population and the use of drugs in treating chronic health problems (Macdonald et al for the Faculty of Actuaries 2006, Smallwood Report 2005). Smallwood (2005) describes an ‘effectiveness gap’ in conventional medical care in managing chronic illness, which is more common in the elderly population. The costs to society of caring for older people in poor health in the future are likely to be significant. Smallwood (2005) suggests that homeopathy and Complementary and Alternative Medicine (CAM) may contribute to improvement in the health and well being of older people in our society.

Homeopathy is a form of complementary medicine which treats the whole person using natural remedies to promote a healing reaction. Homeopathy is described by the Society of Homeopaths as a therapy that is safe, non-toxic, has no side effects and can be used to treat most health problems at all stages of life (Society of Homeopaths 2006). The World Health Organisation (WHO) estimates that homeopathy is the second most popular complementary therapy in the world, practised in about 67 countries with 300 million users (WHO 2004). Despite the widespread use of homeopathy, research into its effectiveness is frequently the subject of debate because there is currently no scientific explanation for its mechanism of action.

This study will attempt to explore common themes in patient responses to homeopathic treatment and connections with common life experiences in the 55+ age group. The study of the homeopathic treatment process will also include consideration of the therapeutic

relationship and other influences on well being such as self care and individual beliefs about health and healing.

The aim of this study is to address the following research questions:

- ❑ Is homeopathy perceived to be effective in improving health and well being and quality of life in the 55+ age group?
- ❑ What are the common themes in the experience of homeopathic treatment described by participants in this study?

The mixed methodology chosen for this research study attempts to answer these questions by taking a pragmatic approach, using different methods of data collection and valuing different perspectives. The homeopath providing treatment is also the researcher, and while this may support the interaction with participants (Martens 2008) the potential for bias is acknowledged.

The literature review considers current research and theoretical perspectives on ageing and health related issues, including the impact of individual beliefs on quality of life and the experience of ill health. The literature on health beliefs generally is also considered, taking account of the impact of the therapeutic relationship and the placebo effect on participants in any research study. Consideration is also given to self care issues which might impact on homeopathic treatment and research findings. Homeopathy is discussed from both a historical and a contemporary perspective, presenting the theory and philosophy of classical homeopathy as described by Samuel Hahnemann (1810) the founder of homeopathy, but also taking account of the impact of debate about its efficacy on research findings. Particular attention is given to published studies of homeopathy in order to show the quantity and nature of the research, but also to highlight the lack of research into homeopathy as a complex intervention and for the 55+ age group.

The methodology section considers a range of philosophical perspectives, focusing on the pragmatic view chosen for this research. Issues of validity and reliability are explored and the embedded research design is described. The different types of data collection are

presented and a rationale provided for choosing these methods. Qualitative data is the primary data source, including interviews, case notes and the practitioner's reflective journal. Quantitative data is the secondary source and includes participant responses to the questionnaires Measure Your Own Medical Outcomes (MYMOP) and SF-36. Although a mixed methodology is chosen the data sources are not combined to produce a common outcome but presented separately. The aim of this approach is to allow the voice of the participants to be clearly heard, while presenting more objective quantitative data as an additional source of information.

The results section includes direct quotations from participant interviews, summaries of information provided in case notes and the practitioner's reflective journal, and descriptive statistics gathered from questionnaires. Because of the small number of participants, the data has largely been presented in its original form, rather than interpreted by the researcher. This was also designed to limit researcher bias in the presentation of results and to ensure that the views of the participants were clearly stated in the final presentation of data.

Discussion of the research data and the associated literature focuses on the outcomes of homeopathic treatment and the themes which emerged from participant interviews. The aim of this section is to address the research questions in detail and present the findings of this study in the context of other research and related societal issues. The conclusions to the study follow directly from this discussion, identifying key findings and implications from the study for future research and health care.

Homeopathy as a healing intervention has been considered in many research studies. It is hoped that this study will provide new insights into the use of homeopathy as a therapeutic intervention. Viewing homeopathy as a complex intervention takes account of the remedy, the interaction of the participants with the homeopath and self care strategies which arise from a greater focus on health issues during treatment. Most importantly, this study will consider homeopathic treatment as more than a remedy reaction.



# CHAPTER 1: LITERATURE REVIEW

This chapter includes information gathered from literature on the subject of ageing, associated health issues, healing and homeopathy, including:

- ❑ an account of common health problems in the 55+ age group and the associated cost to individuals and society
- ❑ commentary on beliefs and perceptions about health, healing and illness
- ❑ issues relating to the therapeutic relationship and the placebo effect
- ❑ commentary about how these issues relate to homeopathy
- ❑ an account of homeopathy, including its history and philosophy
- ❑ a summary of key research carried out into the effectiveness of homeopathy

A comprehensive literature review was conducted, gathering information from a variety of sources including:

- ❑ online search, reference and alert systems, such as: Biomed Central (<http://www.biomedcentral.com>), Google Scholar (<http://scholar.google.co.uk>), Science Direct ([www.sciencedirect.com](http://www.sciencedirect.com)), and Scopus (<http://www.scopus.com>)
- ❑ library resources at Queen Margaret University, the University of Aberdeen, the Open University, the Cochrane Library, the Virtual Health Library and the National Library of Scotland
- ❑ national and international statistics from Europa, the website for the European Union, and the UK government and Scottish Government websites
- ❑ The Society of Homeopaths, the Faculty of Homeopaths, the Research Council for Complementary Medicine and organisations associated with Complementary and Alternative Medicine (CAM)

The following table lists the search categories and the key terms used. Searches were carried out using different categories and terms in combination, for example, 'homeopathy+placebo'.

**Table 1: Terms used for literature search**

<b>Category</b>	<b>Search term</b>
Homeopathy:	history, philosophy, remedy, research, CAM, training, animal studies, water+memory
55+ age group:	ageing, older people, elderly, research, common illnesses, health statistics
Health and healing:	beliefs+health, placebo, therapeutic relationship, stress, psychoneuroimmunology, counselling
Medicine:	drug use, medicines, pharmaceutical companies, drug reactions, costs, polypharmacy, nanopharmacology, environment
Self care:	exercise, diet, relaxation
Research:	methodology, quantitative, qualitative, narrative, pragmatism, constructivism, positivism, validity, reliability, grounded theory, interpretative phenomenological approach, evidence based, SF-36, MYMOP, plausibility criteria

## 1.1 AN AGEING POPULATION

“...individuals age to the extent that they acquire poor health, and they remain young to the extent that they maintain good health” (Scrutton 1992:2)

The 55+ age group has been chosen for this research study because in our society this is a time of life when changes commonly associated with ageing may be experienced. This includes changes in working life and family responsibilities, inevitable losses and changes in health status. Statistically it is a time when people consult their GP more frequently than they did when they were younger and report more health problems (BMA 2009).

Any age chosen to represent the beginning of a phase of life and the associated characteristics cannot be representative of everyone in that age group. Definitions of ageing focus on different aspects of life experience. The Department of Health *National Service Framework for Older People* (2001) defines ageing by referring to different stages in later life. The stage, ‘Entering old age’ is defined as those people who have completed their career in paid work or child rearing. This can include people as young as 50 or those who leave employment at the official retirement age of 65. In the quotation above, Scrutton (1992) gives a definition of ageing based on health status rather than age. He goes on to consider alternative approaches to maintaining health in later life. Hurley, writing in the *Homeopath* (2005) also rejects chronological age as a way of defining the term ‘elderly’ and regards it as a state of being.

The Office for National Statistics (2009) confirms that life expectancy is increasing for the UK population generally. In Scotland life expectancy for males has increased from 71.5 years in 1991 to 75 years in 2008. For females the increase is less, with a life expectancy of 77.1 years in 1991 and 79.9 years in 2008, but still the trend is upwards. Scottish Neighbourhood Statistics (2009) provide statistics for population and health in Scotland. They give the total population for Scotland in 2008 as 5,168,500. The percentage of the total population who were of pensionable age in 2008 was given as



19.68%, an increase of approximately 1% on the 2001 figure. National Statistics (2005) state that the percentage of the population aged 65 or over rose from 13% in 1971 to 16% in 2005. This trend is predicted to continue over the first half of this century as the larger number of people born after the Second World War and during the 1960's become older. The total number of people of pensionable age is predicted to rise by 8% by 2021 according to MacDonald et al (2001).

All these statistics support the view that older people are likely to make up a larger part of the population in the future. This means that their needs will be an important issue for society, as well as for the individuals in this age group.

### **1.1.1 Health problems commonly experienced in the 55+ age group**

“There is no doubt that many men and women have their first serious brush with disastrous loss of health in middle age... the cumulative effects of unhealthy habits and patterns of living make themselves known for the first time, as the natural resilience of the body inevitably begins to diminish.” (Andrew Weil 1997: 28)

A study commissioned by the Faculty of Actuaries (Macdonald et al 2006) to examine the issue of health expectancy in Scotland predicted that the average Scot will live longer than previous generations but will suffer from chronic ill health from about the age of 60. According to the Office for National Statistics (2005), this age group is also statistically more likely to have health problems that require treatment. Age Concern (2005) confirms that most older people live in their own homes and are not dependent on others for their care, but as people grow older they are more likely to develop health problems which limit their ability to live active and productive lives.

Collerton et al (2007) also refer to the change in age structure of the UK population characterized by increased life expectancy and age as the single largest risk factor for most medical conditions. The aim of their Newcastle 85+ study was to examine the spectrum of health in 800 people in the 85+ age group and therefore to advance the

understanding of the biological nature of ageing. Their particular focus was on underlying variability in health and the relationship between health, nutrition and biological markers of the ageing process. As a result of a multi-dimensional health assessment of participants they conclude that some of the oldest people in the population preserve high levels of health and functional ability.

Further consideration of the ageing population profile is provided by Franco et al (2007) who are concerned that there has not been an increase in disease-free life expectancy. A large proportion of the 60+ age group suffer from chronic illness or disability. They believe that ageing is often perceived clinically as a collection of diseases but in fact it is a multi-factorial process, involving progressive loss of function and vulnerability to ill health. They refer to the need for an action plan for ageing research in the UK, identifying the economic advantages of longevity and the potential for healthy individuals to be productive members of society for longer.

Many health problems are more common in an ageing population. These include major health problems such as heart disease, stroke and cancer, and also chronic illnesses such as arthritis, respiratory and digestive illnesses. Beaglehole et al (2007) refer to chronic diseases as a leading cause of death and disability with profound economic effects. They refer to the surprising neglect of this issue on the global health agenda. The WHO proposed a global goal for preventing chronic diseases which they believe could avoid 36 million deaths by 2015.

Many older people have complex health problems and may be taking a variety of drugs to relieve their symptoms. The prevailing biomedical model of care defines these illnesses as a malfunction of particular parts of the body (Lee-Treweek et al 2005). The disease located in that part of the body is then the focus of treatment. The availability of pharmaceutical medicines may mean that other methods of managing symptoms are not explored. As a result, many older people experience a decline in their quality of life because of the side effects of conventional medication (Sullivan 2003).

Multiple morbidity is common in older patients according to Wright et al (2003). The current specialization in medicine leads to some patients receiving care from different doctors and often poor communication and collaboration between primary care sources. A patient with multiple health problems will require multiple referrals and may receive a range of different treatments. Wright et al (2003) believe that it is important to move beyond single diagnoses when treating older people and reduce the use of polypharmacy.

Sullivan (2003), in his study on the cost in morbidity and mortality of polypharmacy, also refers to the widespread use of a combination of drugs, which have been tested individually but not in combination. Knowledge of the effects of a single drug is not an indication of how the drug will react when prescribed in combination with other pharmacological medicines. Many hospital admissions of elderly patients for drug toxicity occur as a result of drug-drug interactions (Sullivan 2003).

Additionally, Souter (1993) refers to the effects of loss, trauma and retirement on this age group. These life events and the physical effects of ageing combine to increase the likelihood of ill health at this stage in life.

Many of the chronic health problems experienced by older people are not easily resolved by biomedical treatment methods. Smallwood (2005) refers to this as the 'effectiveness gap' in current health care. In order to reduce this effectiveness gap and make cost savings he suggests greater use could be made of complementary therapies to treat chronic ill health, offering both symptom relief and support for individual sufferers.

People in the 55+ age group have health issues which may have a significant impact on their lives and the society they live in. The literature on the subject highlights the importance of maintaining good health for older people. There are concerns about the current use of pharmaceutical drugs to treat the range of health problems experienced by older people. The treatment methods that are currently preferred for older people also have a significant cost associated with them (Sullivan 2003). As the older population increases it may be difficult for society to meet this cost. There is an awareness of the

potential of complementary medicine to contribute to current health agendas for older people (Smallwood 2005). There is also a desire to see older people continuing to contribute to society and to reduce the costs associated with ill health and disability.

### **1.1.2 The cost of health problems in the 55+ age group**

“The potential value of homeopathy to older people arises from their vulnerability to iatrogenic consequences of allopathic medicine.” (Scrutton 1992: 140)

There is increasing concern about the cost of health problems in an ageing population, not only the financial cost, but also the cost in human suffering and the risks to the environment of pollution caused by pharmaceutical medicines (Smallwood 2005, British Medical Association (BMA) 2007, the Environment Agency 2007).

Milton (2008) refers to government statistics which indicate that a fifth of the UK population is over the age of 60 but this group receives 59% of prescribed medicines. He sees prescribing for this age group as problematic as they often have several co-existing medical problems and take multiple drugs. This has cost implications but also poses the risk of drug-drug interactions and side effects. He also refers to the changes in the body which take place with ageing and make the distribution, metabolism and excretion of drugs less predictable. These changes include reduction in renal clearance which means that there is reduced excretion of some medicines. Older people are also more sensitive to the effects of drugs. Milton (2008) concludes that polypharmacy is common in older people and is associated with increased adverse drug reactions and hospital admissions.

In a report on trends in GP consultations, Eastern Region Public Health Observatory (ERPHO 2009) state that in England and Wales the highest rate of consultations for different age groups was in the 65-74 age group for women and 75+ for men. The BMA (2009) report a rise in GP consultations in the whole population and note that as the highest consultation rates are in the elderly, these are also likely to increase. The use of prescription drugs has also increased. GP's prescribed 918 million medicines in 2006

compared with 721 million in 2002. The British Medical Association is concerned that the National Health Service (NHS) will not be able to cope with escalating patient demands for treatment (BMA 2007).

There is also concern about the cost of adverse reactions to prescribed drugs. Approximately 250,000 serious adverse reactions to pharmaceutical drugs are reported every year in the UK (Edward Leigh 2006). Pirmohamed et al (2004) calculated the projected annual cost to the NHS of hospital admissions as a result of adverse drug reactions as £466m for the adult population. They concluded that this is an unacceptable cost both in human suffering and in financial terms. As the sector of the population which uses the most medication is the older generation, the cost to them is likely to be the greatest. Up to 30% of hospital admissions of older people are related to adverse drug reactions caused by inappropriate prescribing to older patients (Hamilton et al 2009). The prescription of multiple medications for a range of different conditions exacerbates the risk to patients. This risk is likely to grow as the ageing population increases in size.

There is a financial cost associated with medical care, but there is also a human cost in terms of suffering and disability. Mangin et al (2007) argue that preventative treatments in elderly people change the cause of death, for example from heart attacks to cancer. They believe that preventative interventions are encouraged in our society, and this can be harmful for those taking the medication and expensive for the health service. Their view is that the human body has a finite functional life and age is a fundamental cause of ill health. The single disease perspective leads to treatment of one health outcome to prolong life, irrespective of other health conditions. They also note that drug companies can make huge financial gains if specific pharmaceutical interventions are widely prescribed for large numbers of the population.

There is an increasing interest in less aggressive forms of treatment for ill health and also individual responsibility for health care. A survey carried out by the market analysts group, Mintel (2007) found that Britons spend £191m on alternative treatments a year and that this is likely to increase to £250m by 2011. They believe that this growth is

partly attributable to the ageing population, but also to scientific findings which demonstrate the efficacy of some products and a desire for less invasive forms of treatment.

John Saxton (2006) president of the Faculty of Homeopathy, the organization representing medically qualified homeopaths, states that homeopathy is extremely cost effective and could be used to reduce financial pressures on the NHS, by as much as 4% or £190 million a year.

There is also an environmental cost related to the use of pharmaceutical medicines. Approximately 3000 pharmaceuticals are licensed for human use in the United Kingdom. These enter the aquatic environment when excreted by humans and during the manufacturing process. Although not yet found in levels that are toxic, there is concern about the long term effects of pharmaceutical products on the environment (The Environment Agency 2007).

Predictions of life expectancy are important indicators for government and health care providers of the future health care needs of the population. A different prediction which may be equally important in planning for the future is provided by measuring quality of life for older people. The concept of healthy life years takes account of the potential of older people to contribute to society, as well as considering projected health care needs. Jagger et al (2008) reviewed inequalities in healthy life years in the 25 countries of the European Union and found significant differences in the 50+ group in different countries. Although the life expectancy at 65 years has risen considerably, this in itself does not mean a healthier older population. They conclude that there needs to be major improvement in the health of the older population if they are to be included in the workforce of the future. Butler et al (2008) consider new models of health promotion and disease prevention for the 21<sup>st</sup> century. They refer to increased susceptibility to disease as people grow older and the potential to produce, “unprecedented social, economic, and health dividends” if ageing can be combined with extended years of healthy life.

## 1.2 FACTORS WHICH IMPACT ON HEALTH AND HEALING

### 1.2.1 What is health?

“the well body is almost invisible to the individual” (Lee-Treweek et al 2005: 118)

Lee-Treweek highlights a difficulty in defining health, as wellness is often unnoticed.

Classical homeopathy bases its view of health on a definition provided by Samuel Hahnemann in his *Organon of Medicine* (1810: aphorism 9):

“In the healthy condition of man, the spiritual vital force, the dynamis that animates the material body, rules with unbounded sway, and retains all the parts of the organism in admirable, harmonious, vital operation, as regards both sensations and functions, so that our indwelling, reason-gifted mind can freely employ this living, healthy instrument for the higher purposes of existence.”

The World Health Organisation (WHO 1948) also focuses on the spiritual and creative aspects of good health, not just the absence of pain or symptoms. WHO defines health as:

“a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO 1948)

The effectiveness of health interventions may be measured by the absence of symptoms of a defined disease, but defining wellness takes account of much more than the absence of symptoms. Curtice and Trotter (1999) note that a healthy person shows spontaneity and ease in the way they respond to new challenges in life. Featherstone and Forsyth (1999) also define health as the ability to respond to situations in a way that increases a sense of autonomy, spontaneity and joy.

Different models of health focus on different aspects of individual physical, emotional and social situations. Siddell (1995) believes that defining health is “an epistemological

issue” with different aspects of health being measured depending on the model of health chosen.

Siddell (1995) describes four different models of health:

- ❑ the biomedical model which sees health as the absence of disease
- ❑ the psychological model which focuses on the healthy personality
- ❑ the biographical explanation of health, seeing individuals as a product of their life experiences and their responses to these experiences
- ❑ the environmental view, which takes account of poverty and social issues such as housing

The difficulty in measuring disease and health is compounded by individual perceptions of health and individual circumstances. Antonovsky’s (1979) salutogenic paradigm defines health as a continuum in which we move from ‘ease’ to ‘disease’ and back to ‘ease’. No one is totally healthy or diseased. More recently Weil (1997) expressed the view that health is not static but breaks down periodically. He believes that the body is able to defend itself against threats on a physical, emotional and energetic level depending on individual, circumstances and support available at the time.

These theories attempt to define in general terms what is experienced by the individual very personally. It is possible that all the factors considered in these definitions have some influence on individual perceptions of health and illness.

### **1.2.2 Beliefs about health, illness and ageing**

Kenton (2002) refers to the ‘death curses’ used by Aboriginal witch doctors, which would lead to young, healthy individuals sickening and dying as a result of their belief in the curse. Similarly, in our society, she believes that older people accept the image of ageing as one of physical and mental decline. This can have a powerful effect on the process of



ageing by creating self fulfilling beliefs about the inevitability of decline and disability in old age. She cites the work of Fiatarone (1990) with the elderly in which she helped frail institutionalised elderly people to improve their physical capacity through exercise, suggesting that improving physical performance is possible even in later life. The research on the longest lived peoples of the world also suggests that their healthy longevity is based on positive expectations of ageing as a time of continued activity and valued contribution to their community (Friedrich 2002).

Larkin (1999) develops this theme. She believes that the growing number of centenarians in our society can point the way to healthy ageing and she challenges the idea that the older we get the sicker we get. She refers to studies which show that people who are long lived tend to have a calm, communicative, cheerful, optimistic and tolerant personality. They have often coped well with life's adversities and are more capable, responsible and less prone to anxiety. Centenarians also tend to eat and exercise moderately throughout life.

The view of ageing as a steady decline in health and independence is challenged by research on centenarians, according to Friedrich (2002). He refers to the ongoing New England Centenarian Study which has found evidence that some people markedly delay or escape age-associated diseases. Research into the children of centenarians suggests that there is a familial component to longevity but environmental factors have also been considered.

Some of the expectations about ageing and health issues in our culture relate to the medical view of old age. Moynihan and Smith (2005) refer to the medicalisation of people's lives and the possibility that medical science will make enough discoveries to define everyone as sick in some way:

“the cost of trying to defeat death, pain and sickness is unlimited, and beyond a certain point every penny spent may make the problem worse, eroding still further the human capacity to cope with reality.” (Moynihan and Smith 2005: 35)

Christie (2006) refers to doctors' concerns that healthy people are being turned into worried patients as a result of international guidelines that widen the range of people to be targeted for treatment with blood pressure and cholesterol lowering drugs. These concerns were expressed at a conference at the Royal College of Physicians in Edinburgh in 2006, where two thirds of delegates voted to support a motion associating the drug industry with the drive to treat more cardiovascular risk factors unnecessarily.

However, research suggests that individuals also have views about their health. Siddell (2005) refers to surveys in the UK and the USA which found that older people consistently rate their health as good, when in objective terms their health is poor. Hagger and Orbell (2003) refer to key assumptions in perception of ageing studies in which individuals see their illness as something with a label and symptoms. They have beliefs about its severity, likely course and duration. They also have beliefs about the impact of illness on their lives and their personal way of managing illness. The hope of an operation or treatment in the future can also affect perceptions of the manageability of illness. Support networks can make a difference to the perception of illness too (Hagger and Orbell 2003). Individuals also have beliefs about the likely cause of their illness and the emotional response that their illness generates in others. Barker et al (2007) highlight the potential role of self perception in promoting health in later life.

Siddell (1995) also refers to individual perceptions of illness and health. She cites Claudine Herzlick (1973) who found individuals identifying illness variously as a destroyer, as an occupation and as a liberator. She also cites Wendy Stainton-Rogers (1992) who sees people giving different explanations for health at different stages in their lives. They see the body variously as a machine, or the body under siege, or good health as the result of good living, poor health related to lack of resources or power or information, good health as a gift from God, good health as a result of willpower and finally as a matter of individual responsibility and choice. Blaxter (1990) found that individuals viewed health as being a physical problem but also about feelings and their ability to do things. Rory Williams (1990) found the most significant view of health was the ability to function. He also noted the determination not to give in to illness.

Stone and Katz (2005) also refer to the diverse and contradictory explanations of health provided by different populations. They cite a study of older people in Aberdeen by Williams (1983) in which participants variously defined health as the absence of disease, as stamina, as inner strength and the capacity to cope with chronic pain. They also refer to research by Herzlich and Pierret (1986) which shows that lay people usually take a variety of factors into account when looking for the cause of illness, including climate, working conditions, bereavement and other factors and do not simply accept that ill health is caused by pathogens or disease processes.

The view that it is difficult to define health because it is such a subjective experience is shared by Capra (2005). He refers to sickness as an escape route and a way of dealing with stressful life situations. He sees ill health as an opportunity for introspection, so that the original problem and the reason for choosing a particular escape route can be brought to the surface and resolved.

Personal Construct Theory developed by George Kelly (1969) puts forward the idea that there are no absolute truths only our own interpretation of what we experience. We can construct a negative or positive view of our health and this may then have an influence on our experience of diagnosis, disease and healing. Knowledge about health is learned from family, community and official sources of health information such as doctors and government, but individual health beliefs are also based on experience and modified over time (Stone and Katz 2005). People use different constructs to make sense of illness, including scientific explanations but also reflections on personal experience and beliefs about why things happen to individuals.

“Thus people live with, and draw on, multiple realities and paradigms for understanding health.” (Stone and Katz 2005:148)

Social theorists have categorized models of health belief which take account of causes of ill health and different behaviours associated with illness and seeking treatment. Greenhalgh (2000) describes biomedicine as one of the most polarized models of health care, lacking a means of incorporating and understanding the emotional pain which often

accompanies physical symptoms of ill health. She also refers to Antonovsky's (1979) salutogenic model of health which identifies the limitations of the biomedical model by making a connection between stress and coping mechanisms as a way of explaining why some people remain well despite the difficulties they face. Antonovsky refers to the sense of coherence which is central to the ability to cope. The components of this sense of coherence are comprehensibility, manageability and meaningfulness. Antonovsky's model recognizes that to function well we need social stability, rewarding occupations and freedom from stress and persecution (Stone and Katz 2005).

Different cultures and different social values also affect perceptions of ageing. Bakewell (2006) refers to a popular view of ageing in our society as suffering from chronic health problems, disability and dependence on relatives or the state, which labels the older person as a burden. Images of older people presented in the media, literature and even on sign posts suggest that they have difficulty walking and taking care of themselves.



**Figure 1: Road sign indicating elderly people crossing the road**

News items on caring for the elderly often show older people in a nursing home. Much of the research on ageing has focused on dementia and nursing home care, even though these only affect about 5% of the population (Age Concern 2005). The presentation of older people in our society often depicts grandparents in a stereotypical way as having grey hair, glasses and a walking stick. There is a resistance to the idea of growth and productivity in old age and older people can be perceived as helpless patients in need of care. This view of ageing is one of decline and chronic ill health, promoting an assumption that older people are lonely, unhappy and dependent.

A counter view of ageing is that of ‘grey power’ and ‘silver surfers’, presenting an older generation which has a good standard of living, is computer literate and has the capacity to be valuable members of society. This has been described as the ‘super oldie model’ (Siddell 1995). The promotion of anti-ageing products and cosmetic surgery presents youthfulness as desirable and may foster a climate of denial as far as the natural ageing process is concerned. Age is then perceived as an absence of youth rather than a positive state. This leads to a pre-occupation with the problems of ageing, rather than recognition of the benefits. Legislation against ageism such as the Age Discrimination Act (2002) and the Employment Equality (Age) Regulations (2006) have given older people more rights but it may take longer for society to change its view of age as a defining characteristic.

The different perspectives on ageing held by individuals and cultures increase the difficulty of first defining age and then measuring the experience of ageing. The WHOQOL Group (1993) view ageing as a broad ranging concept affected by personal health and relationships to others and the environment. Barker et al (2007) state that research on self perceptions of ageing is limited because of a lack of adequate measures. Their study on the Aging Perceptions Questionnaire refers to “the complex and multifaceted nature of the aging experience” (2007: 3).

In summary, societies and individuals define health and well being in different ways, based on cultural mores and past experience. The difficulty in measuring health and well being is closely related to the different perceptions of health. In modern society,

perceptions of health and ageing are influenced by advertising and media presentation of older people. This may in turn become a self fulfilling prophecy as individuals believe that decline in physical and mental health is inevitable. Research into those individuals who live to be a 100 and maintain good health suggests that decline in old age is not inevitable and there is value in trying to promote ways of living that enhance good health and well being.

### **1.2.3 The therapeutic relationship and the patient's story**

The World Health Organisation (1998) notes that the medical model of care focuses on treatment using medicines and surgery and places less importance on the therapeutic relationship with the medical professional. They emphasise the importance of looking beyond the physical care of an individual and taking account of faith, hope and compassion as valuable elements in the healing process.

Stone and Katz (2005) define the therapeutic relationship as the role of a therapist working with clients, or the rapport between them, or the healing process that occurs as a result of the interaction between them. Therapeutic relationships can also occur in social or family situations when concerns and sympathy are shared. The term implies a meaningful experience between two people which is not the same as friendship. It has a clear purpose and boundaries and is based on mutual respect. It implies a connection between the therapist and client over a period of time based on trust and the 'do no harm' principle. There may be strong expectations of a positive outcome and an active participation in the healing process by the client or patient. The healing effect of the therapeutic relationship can include alleviation of symptoms or changes in behaviour which enable the individual to be more at ease with their situation. It is a supportive relationship but also aims to encourage individuals to believe that they can become independent and look after themselves.

Definitions of the therapeutic relationship imply that it involves time spent on caring and listening. Research into doctors' attitudes to Complementary and Alternative Medicine (CAM) carried out by Maha and Shaw (2007) concludes that doctors view the extra time given in CAM consultations as a vital part of holistic practice, allowing patients to tell their stories and allowing the doctor to understand the patient as well as identifying symptoms. Although this was a small exploratory study there was evidence that those doctors who were positive about CAM were those with professional experience of the benefits of CAM to their patients.

The time available for patients to tell their story to a health care professional can have an impact on the type of account that is given of their health and circumstances. Siddell (1995) cites the work of Jocelyn Cornwall (1984) in which she refers to the difference between public and private accounts of illness. Public accounts tend to be linear accounts of events. In contrast, private accounts of illness tend to be non-linear and linked to life events. This approach to describing illness can be less important in conventional medical treatment as "the doctor seeks those parts of narrative that fit the stories of disease" (Greenhalgh and Hurwitz 2000: 85).

Homeopathic treatment aims to be holistic and focussed on the narrative and the needs of the individual, rather than specific symptoms. There is no challenge to the patient's world view or perception of an experience. This holistic approach often deals with longstanding health issues which have become particularly problematic as a result of the ageing process. Homeopathic health care can have an important role to play in allowing people to talk about their experiences. There are several key aspects to the homeopathic interview that have important links with the narrative of life experience. Patients will often reveal that symptoms started at the time of a particular event. There are often maintaining causes such as difficult relationships, work pressures or unresolved emotional issues that are part of the story. Patients will describe feelings about work and relationships that take over their lives and contribute to their illness. Homeopathy takes note of the strangeness of symptoms, as well as the detail of common complaints and

common experiences. Alertness to the use of language indicates that an individual is experiencing illness in a particular way (Thompson 2005).

Millenson (1995) believes that current treatment sees illness as a random event, not as something with meaning and a message for the sufferer. He believes that by looking for meaning in the patient's narrative we get a prognosis for the disease, and hope and empowerment for the sufferer through greater understanding of life's disharmonies.

#### **1.2.4 The placebo effect**

The Latin word 'placebo' means *I shall please*, or in the context of the Old Testament of the Bible, *I shall please the Lord* (Psalm 116). The placebo effect refers to improvement in health that comes about as a result of a patient's belief that he or she has received beneficial treatment, even though this is not factually true. In a survey of doctors who prescribe placebos to patients, Sherman and Hickner (2008) found the most common definition of placebo was that it is an intervention which is not expected to have an effect through a known physiological mechanism.

Placebos are not consistently effective and the research into their impact on participants' symptoms provides interesting information about beliefs and perceptions about healing. For example, a placebo given by a doctor is more likely to be effective than one given by a nurse (Thomson 2005). An injection is also more powerful than a pill and a large pill more powerful than a small one. The colour of medicine has also been shown to have an effect eg white pills are more effective for pain and yellow are more effective for depression.

“Thus the appearance of an inert treatment can symbolically convey the notion of healing, and affect the recipient's response.” (Thomson 2005: 41)

The concept of a placebo personality type has also been explored but no evidence has been found to suggest a particular type of person is more likely to respond to placebos.



Smith (2003) refers to extensive tests carried out by parapsychologists to try to find the type of person who is susceptible to placebo, which concluded that no such personality type exists.

Walach (2004) provides a definition of the placebo effect which has strong links with the concept of individualisation in homeopathic treatment, claiming that what is normally called the placebo effect is in fact the self healing capacity of the individual. This self healing is prompted by the context of the therapeutic intervention and the relationship with the therapist.

In his book about the placebo effect and health, Thomson (2005) emphasizes the importance of considering the placebo effect and not the device which produces the effect, such as medication or surgery. He states that in clinical trials which use a placebo, the placebo effect is believed to account for up to 45 % of benefits experienced by participants. This has been seen to be a disadvantage but Thomson believes the success of placebos should be exploited rather than denied. The placebo effect is the product of successful human interaction. “The doctor *is* the placebo.” (Thomson 2005: 65) The placebo itself has no therapeutic effect. It is the circumstances and the manner of giving placebos which creates the effect, therefore optimising the relationship between the patient and the doctor also optimises the placebo effect.

Several recent studies into the effectiveness of placebo provide useful insights into the importance of the therapeutic relationship. Kaptchuk et al (2008) carried out research to investigate the placebo effect when using sham acupuncture to treat irritable bowel syndrome. They concluded that factors contributing to the placebo effect can be progressively combined to produce a significantly greater improvement, and the most robust component is the patient-practitioner relationship. They found that the use of placebo treatment and time spent with a sympathetic practitioner produced improvement in 62% of patients which is comparable to the improvement achieved in drug trials for the same condition.

Spiegel and Harrington (2008) comment on the ‘augmented intervention’ in this trial carried out by Kaptchuk et al (2008). Patients received a placebo treatment but also 45 minutes of quality time with a clinician who asked questions about patients’ symptoms and had a warm, friendly manner, showing empathy and positive expectations. Spiegel and Harrington conclude that many people who visit a CAM therapist may experience significant benefit from the opportunity to talk about their experience of illness to an empathetic listener. In their view, rather than dismissing this as mere placebo effect, the medical profession should value the therapeutic relationship as a specific healing tool.

Meissner et al (2007) explored the effects of placebo treatments on objectively measured outcomes in illnesses such as asthma, using evidence from double-blind, randomized trials using placebo controls. Eight out of 16 trials included in their research, using physical parameters as outcomes, showed significant placebo effects. They suggest that this may be because participants are able to monitor progress eg respiratory effort in asthma. They also note that momentary experiences of symptom improvement act as a reward and reinforce changes of autonomic function as in operant conditioning. This may also complement patients’ expectations of improvement raised by suggestions from the clinician administering the placebo. As only 50% of the trials showed this outcome it is possible that there were factors other than placebo which influenced the outcome of treatment.

Researchers from Alberta University analysed 21 studies involving over 46,000 patients with heart disease, of these nearly 20,000 were taking a placebo. They found that it was not the drug or the placebo which made a difference to survival, but the patient’s decision to follow the prescribed regimen of pill taking three times a day (Simpson et al 2006). Using data from 21 studies (46,847 participants) researchers discovered that good adherence to drug treatment regimes compared with poor adherence was associated with lower mortality, but good adherence to placebo treatment was also associated with lower mortality.

The effect of the homeopathic remedy is frequently described as placebo. Mollinger et al (2009) carried out an RCT on 25 healthy volunteers to test out the placebo effect of two homeopathic remedies. They found that homeopathic remedies produce different symptoms from placebo. These were significantly different from placebo (Mann-Whitney test,  $p=0.001$ ). Although this was a small study it does highlight the effects of homeopathic remedies as seen in the original provings of the remedies, which are different from placebo.

It is difficult to provide evidence for the placebo effect because it is based on patient belief and also requires an ongoing patient-clinician relationship. Pittrof and Rubenstein (2008) refer to the placebo effect as ‘medicine’s dirty little secret’ and call for open discussion of the value of the placebo effect in healing, based on strong observational evidence that placebo treatment can lead to measurable and lasting benefits.

### **1.2.5 The impact of stress on health**

The French philosopher Rene Descartes introduced the reductionist approach to health and disease in the seventeenth century and began unraveling the link between emotions and health. Sternberg (2000) sees a need to put the mind and body back together again through research which shows the connections between the immune and nervous systems. She refers to the work of Hans Selye in the 1950’s in identifying the concept of stress and its effect on health.

“stress *can* make you sick because the hormones and nerve pathways activated by stress change the way the immune system responds making it less able to fight invaders.” (Sternberg 2000: 131)

She further suggests that belief systems can improve health. These include conditioning, ritual, prayer and meditation, which might decrease the stress hormones in the body and allow immunosuppressive molecules to play a greater role.

A study by Maluch et al (1998) at Ohio University shows that the relatively mild psychosocial stressor of academic exams can produce immunodeficiency in healthy young students, producing impaired healing of a mucosal wound. Johnson and Godbout (2007) specifically link the ageing process and the gradual decline of the individual's ability to cope with factors that cause stress with an increased probability of disease and death.

Psychoneuroimmunology provides another explanation for the impact of stress on the physical body. Cohen and Kinney (2007) define psychoneuroimmunology as the study of reciprocal interactions among the nervous, endocrine and immune systems. Changes in the immune system are associated with both stress and behavioural conditioning suggesting that the immune system is influenced by the nervous and endocrine system.

The mind body links are also highlighted in the literature on self care, suggesting that the benefits of healthy living have an impact on emotional well being as well as physical health.

### **1.2.6 Self care**

The theory and philosophy of homeopathy includes an awareness of the benefits of healthy living and the need to avoid substances or behaviour that are harmful to health.

Kennedy et al (2007) define self care as the actions individuals take to lead a healthy life style, including meeting their social and emotional needs and preventing further illness or accidents. This is important for older people as highlighted in a study by Deary et al (2007). They carried out a follow up study to the Scottish Mental Survey of 1947 on 70,805 children born in 1936 attending Edinburgh schools in 1947. The same mental ability test was taken by participants aged 70 and results were used to study the social and biological factors which contribute to differences in cognitive ageing. They note the self

care issues which have an effect on normal cognitive ageing, such as smoking, diet, physical fitness, personality, and social and intellectual engagement.

There have been many initiatives from governments and world health organisations to consider different aspects of self care and their importance in helping to maintain good health. Beaglehole et al (2007) refer to the Global Strategy on Diet, Physical Activity, and Health (WHO 2004) which emphasizes the need for countries to develop policies with long-term, sustainable action plans to empower individuals, families and communities to change behaviours that are detrimental to health.

O'Dwyer et al (2007) refer to a range of studies which confirm that exercise improves psychological and physical well being in all age groups, including older people. Her study shows that cognitive decline, which is a normal feature of aging, is also improved as a result of exercise. Donaghy (2007) also reports on the benefits of exercise in improving mental health. She refers to the link between mind and body and the importance of helping people to recognize the mind-body connection and the effect that exercise has on emotional well being. The explanation provided for the benefits of exercise in enhancing mood and well being includes the release of neurotransmitters in the brain associated with elevating mood (Donaghy 2007).

These studies support the view that self care is an essential part of any strategy for longevity and well being of older people. There is, however, also an acknowledgement that changing the behaviour of individuals is not a straightforward matter. Simply telling people that they should practise specific types of self care is not always an effective way of promoting self care (Donaghy 2007). People who are unwell and lack energy have particular difficulty following a healthy lifestyle.

## 1.3 HOMEOPATHY

In this section the background, practice and use of homeopathy are reviewed by:

- ❑ exploring the origins and history of homeopathy
- ❑ outlining the theory and philosophy of homeopathy
- ❑ describing the practice of classical homeopathy
- ❑ summarising its use worldwide
- ❑ referring to the debate about the efficacy of homeopathy

### 1.3.1 The history of homeopathy



**Figure 2: Samuel Hahnemann (1755 – 1843)**

Classical homeopathy is based on the work of Samuel Hahnemann (1755 – 1843) and his philosophy of homeopathy published in the *Organon of Medicine* (1810). Hahnemann was a German doctor who gave up the practice of medicine because he considered the treatments of the time barbaric. He earned his living translating medical texts and while translating Dr William Cullen's *A Treatise on Materia Medica* he became interested in the properties of Peruvian Bark or Cinchona (Quinine), which is used in the treatment of malaria. He took the substance himself and developed the symptoms of malaria. Hahnemann repeated this experiment several times and deduced that if it produced the symptoms in a healthy person, then it might cure the same symptoms in someone who was ill. He referred to this as the theory of like curing like. He went on to test many other

substances using his system of proving to formulate his method of cure. Castro (1990: 4) says:

“Hahnemann had discovered an experimental basis that would systematically yield vastly more accurate and specific information about the individual substances tested. The system was called ‘proving’ (ie testing) a remedy.”

Hahnemann went on to prove about one hundred remedies. Other homeopaths also used his method of proving remedies and there are now over 2000 proved remedies. As with any type of testing or research the credibility of the results depends on the rigour of the methods used. Hahnemann would be described as a research scientist in modern times precisely because his methods were so rigorous (Fraser 1998).

Provings of remedies continue to be carried out, often focusing on substances that were not considered in Hahnemann’s time, such as chocolate and electricity. Modern provings have most frequently been carried out in homeopathic colleges. It is difficult to replicate Hahnemann’s approach exactly as he used fit young men for provings and the students in many homeopathic colleges are predominantly women and often older. It is also difficult to find provers who are not taking conventional medication and who are well and have limited stress in their lives. Concern has been expressed about the focus on new remedies (Adams 2009) and the limitations of some of the methods used in modern provings. Fraser (1998) states that homeopathy since the time of Hahnemann has been based on the scientific collection of evidence and the best homeopathy continues to use these methods.

The methods used for proving remedies were specified by Hahnemann and are detailed in Appendix 1. Records of provings are kept which include the complete detail of the process and outcome. These records are used to create *Materia Medica*, which are reference books detailing and classifying reliable symptoms from the proving. (See example in Appendix 3) The *Materia Medicas* are used in conjunction with homeopathic repertories which list and grade symptoms and link them to remedies which are known to alleviate specific symptoms. *Materia Medica* and repertorisation are now commonly carried out using a computerized system such as *Cara*. (See example in Appendix 2)

Hahnemann was also concerned about iatrogenic symptoms produced by remedies. He had already become aware of the connections between the curative and poisoning effects of medicine in the use of mercury to treat syphilis. This led him to experiment with reducing the dosage of remedies. He discovered that this increased the curative power as well as lessening adverse reactions to the medicine. He recommended serial dilution of the remedies (Hahnemann 1810).

Hahnemann published his first *Materia Medica* in 1805 describing the symptom picture of 27 remedies. In 1810 he published the first edition of the work which is still the basis of classical homeopathy today the *Organon of Medicine*. The sixth edition of this work was published after his death by his wife and included important developments in his thinking about the potency of remedies. By the time of Hahnemann's death in 1843 homeopathy was practised in most European countries.

Hahnemann's discovery of homeopathy came at a time when medical practice could be life threatening (Clover 1989). He pursued two fundamental questions throughout his medical career: what is the nature of disease and how can it be effectively and safely treated? He believed that it was important to clarify principles before applying them regularly in practice. His principles were based on what could be seen as the outer evidence of illness, but also as a revelation of what was happening within.

Other eminent homeopaths continued his work and have contributed greatly to the practice of homeopathy in modern times. Constantine Hering's *Guiding Symptoms* (1879) is still valued today as an accurate description of homeopathic provings. Another American, James Tyler Kent, wrote *The Repertory of the Homeopathic Materia Medica* (1897) which details signs and symptoms of disease and evidence from provings, recorded in the form of rubrics. Each rubric has a list of homeopathic remedies which have proved that symptom.

As well as the provings there are historical records of the successful use of homeopathy in times of serious illness and epidemics. In 1813 homeopathy was used in the successful



treatment of the typhus epidemic and this brought homeopathy into vogue. It also produced a surge of antagonism from allopathic doctors and apothecaries whose livelihood was threatened by the public demand for homeopathy (Castro 1990). In 1831 cholera swept through Europe and was successfully treated with homeopathy. Mortality rates for patients treated with homeopathy were between 2.4 and 21.1% compared with 50% or more in conventional treatment. Hahnemann gave an accurate description of the bacterial cause of cholera well before this was discovered by other scientists (Castro 1990).

By the 1870's homeopathy was meeting the health care needs of the poor through hospitals and dispensaries and of the aristocracy through private practice. Women who could read had access to the publication of guides to the domestic use of homeopathy (Nicholls 2005). The practice of orthodox doctors included bleeding and purging patients and homeopaths of the time challenged this approach with some success.

The use of homeopathy by the royal family increased its popularity with the general population. Dr Margery Blackie (1898–1981) followed by Sir John Weir (1879–1971) were homeopathic physicians to the royal household. They were very influential in renewing interest in homeopathy among British doctors. Nicholls (2005) suggests that royal patronage of homeopathy may have had some influence on its inclusion in the NHS. The first homeopathic hospital in Britain was founded in 1849 and in 1948 the homeopathic hospitals were incorporated into the NHS.



**Figure 3: Hahnemann Hospital Liverpool 1910 (Wellcome Library, London)**

At the end of the nineteenth century homeopathy was becoming less popular and in Britain it remained in something of a decline until the 1960's when there was a resurgence of interest, popularly associated with the 'hippy' movement and also linked to post modernist thinking. This interest in homeopathy led to the establishment of schools of homeopathy, where student homeopaths were trained by a small group of charismatic homeopaths and members of the Druid movement, such as Dr Thomas Maughan, Jerome Whitney and Mary Titchmarsh, who led the revival. Private schools of homeopathy were set up around the country and concern began to be expressed about the unregulated status of the profession. As a result the Society of Homeopaths was set up in 1978 and it became the leading organisation for regulating training and professional standards for non-medically qualified (NMQ) homeopaths. More recently there have been moves to integrate homeopathy into the curriculum of universities. In 1999 the London School of Classical Homeopathy joined the University of Westminster in setting up its first degree course in homeopathy.

At a time when the practice of homeopathy is at its most professional and accountable, there is again evidence of decline. This is despite predictions by organisations, such as Mintel (2007) and researchers such as Witt et al (2008) who claim that the demand for homeopathy is set to increase. Some private schools of homeopathy have closed and homeopaths report a decrease in business. University courses for homeopathy have faced harsh scrutiny and in some cases, such as the University of Central Lancashire homeopathy courses have been discontinued (Lipsett 2008). In Scotland, there are no accredited courses for NMQ homeopaths. Anyone who wishes to train as a homeopath has to use distance learning courses and travel to the south of England for tutorials and assessment. NHS homeopathic hospitals in England have also faced the possibility of closure as questions have been asked about the value of funding homeopathy in the current economic climate.

The philosophy of homeopathy has also been subject to change and new teachings have become popular, but these in turn have been challenged by traditionalists. Moskowitz (2004) refers to the teachings of contemporary homeopaths such as Rajan Sankaran, Jan

Scholten, Jeremy Sherr and Nancy Herrick, which have been criticised for being against the spirit of the Hahnemannian tradition. Sankaran has developed theories relating to core delusions. Scholten has related remedies to the Periodic Table. Herring has created remedy families and kingdoms. Moskowitz (2004) believes that Hahnemann would have categorised their theories as empty speculations. In contrast to these so called speculative theories, Hahnemann tried to develop rules for reliable practice of the healing art. His system of proving of remedies was a scientific way of working (Fraser 1998) which is not evident in some contemporary practice, for example, symptoms elicited in a group discussion. The approaches taken by homeopaths like Sankaran are condemned by some classical homeopaths because they generalise instead of individualise cases. The use of essences by homeopaths like Vithoulkas and the emphasis on signatures (connections between non-homeopathic properties of the original substance/plant and the symptoms of the patient) in the work of Herrick is also criticised for focusing too much on one aspect of the remedy, often the emotional issues, and missing a great deal of the potential of the remedy for curing diverse symptoms (Moskowitz 2004).

Adams (2009) also questions some of the new approaches to homeopathy, specifically the introduction of many new remedies. He believes that there may be some gaps in the old materia medica but not enough to warrant all the new remedies being introduced. He believes that homeopaths confirm the remedy picture and the value of the traditional remedies every time the remedies are successfully used in homeopathic practice. Ignoring this information results from a “fascination with the new and the unknown”. He fears the use of techniques associated with psychotherapy, based on a different model of understanding health and well being, which explores past trauma rather than focusing on signs of imbalance in the current state of the patient.

Historically, homeopathy has survived many challenges and changes in the provision and legislation of medicine. There have also been changes in the approaches to practising homeopathy, but for many homeopaths the philosophy of Hahnemann published in his *Organon of Medicine* (1810) is still valid today and is the basis of their practice. These

principles and the associated philosophy form the basis of what is referred to today as classical homeopathy.

### 1.3.2 Aims of homeopathic treatment

“The physician’s high and only mission is to restore the sick to health, to cure, as it is termed. The highest ideal of cure is rapid, gentle and permanent restoration of health, or removal and annihilation of the disease in its whole extent, in the shortest, most reliable, and most harmless way, on easily comprehensible principles.” (Hahnemann 1810)

These aims outlined by Hahnemann are an important basis for homeopathic practice but in modern times the aims of homeopathic treatment are not expressed in terms of cure. The Society of Homeopaths (2006) describes homeopathy as a therapy that is safe, non-toxic, has no side effects and can be used to treat most health problems at all stages of life. Homeopathic remedies described in homeopathic Materia Medica (see example in Appendix 3) refer to many different symptoms and diseases, both chronic and acute, which can be treated homeopathically. In modern practice, however, the approach to treatment is limited by legal and ethical constraints (Society of Homeopaths Code of Ethics 2010) and advances in modern medicine and screening procedures. Patients are advised to seek medical advice for a range of symptoms and conventional treatment is often used alongside homeopathic treatment.

Despite the legal and ethical limitations placed on homeopathic practice the aims of classical homeopathic treatment are still based on Hahnemann’s philosophy outlined in his *Organon of Medicine* (1810). These are:

- ❑ to relieve suffering and improve identified symptoms
- ❑ to promote well being
- ❑ to improve energy levels and motivation
- ❑ to restore emotional calm and be at ease with self and with others
- ❑ to foster the ability to cope with change and difficulties
- ❑ to be creative in whatever way the individual identifies creativity

### 1.3.3 Theory and philosophy of homeopathy

The fundamental principles outlined by Hahnemann in his *Organon of Medicine* (1810) remain unchanged as the cornerstone of classical homeopathy. Misha Norland (2004), writing about homeopathic principles in the Society of Homeopath's journal, defines the 'three pillars' of homeopathy as the stimulation of the individual's vital or life force, the law of similars and the potentisation of remedies.

Homeopathy is based on the theory that the body has a vital force which affects all aspects of life and health. This concept of energy and life force is common in many cultures (Kenton 2002). This contrasts with the biochemical view of ageing based on the assumption that life can be explained by the laws of chemistry and physiology. The homeopathic remedies can also be prescribed at different levels or potencies. This is based on the belief that the potency of the remedy should match the energy levels of the patient and the aggressiveness of their symptoms.

The principle of 'like cures like' is the basis for the prescription of homeopathic remedies. The prescription of a homeopathic remedy is individualised in order to treat the whole person not a diagnosed disease. Patients with a similar diagnosis could be prescribed very different remedies based on their personality, experience of ill health and life history. The physical symptoms of the individual and the way the personality has been temporarily changed by illness are carefully recorded in order to find a match with a remedy picture.

Susceptibility to illness is another key homeopathic principle. Individuals are susceptible to different illnesses at different times in their lives. This susceptibility can result from inherited traits, personality, life style and life experiences. All contribute to the individualised approach to selecting a remedy. (In the case of acute illness or an epidemic where most of the population react in the same way to the disease, a single remedy may be prescribed for most patients.)

Hahnemann described himself as, ‘no friend of mixtures of medicine’ believing that if remedies have not been ‘proved’ together their combined action is not known and they are likely to modify the expected reactions to an individual remedy. He advocated the prescription of a single remedy, then observing and assessing the response before further treatment is given. This principle of ‘watch and wait’ is an important part of homeopathic treatment.

Hahnemann’s homeopathic philosophy has been further developed by homeopaths such as Constantine Hering (1800-80) to include the belief that the body tries to move the symptoms away from major organs and onto the surface or the extremities of the body. In classical homeopathy it is regarded as a positive sign if a symptom from within, for example, joint pain improves, but a skin symptom develops which would then be treated as a new symptom. This is referred to as the law or direction of cure.

Homeopathic treatment may lead to a healing crisis. It is common for patients treated with homeopathy to develop a cold or other minor ailment. Their recovery from this ailment may then mark the beginning of a significant improvement in their health. There may also be a return of old symptoms. As the body searches for healing, former symptoms may return briefly. These common responses to homeopathic treatment are linked to a belief in the negative outcomes of suppressing symptoms or emotions. Many conventional medications suppress symptoms, therefore denying the direction of cure. Similarly, emotions can be suppressed, leading to increased vulnerability to illness and mental or emotional breakdown.

Treatment with homeopathic remedies can lead to aggravation of symptoms, in the same way that vaccination can produce symptoms of the illness it is designed to prevent. This aggravation can be of any significant symptom or some form of emotional release. It is usually regarded as evidence of a well chosen remedy and a sign that the body is looking for cure. Management of homeopathic aggravation is very important in order to protect the patient from suffering, but also to avoid alienating the patient. Elizabeth Thompson (2004) conducted an audit of remedy reactions at the Bristol Homeopathic Hospital,

sampling 116 patients over a two month period. She included adverse effects of the remedies, aggravations, new symptoms and the return of old symptoms and was able to confirm their role in the healing process.

Hahnemann believed in the effect of hereditary and life experiences on the health of a patient. He referred specifically to psoric, sycotic, syphilitic and tubercular miasms. Other miasms have been added to the list in modern times, such as cancer miasms. Specific remedies are considered when symptoms of these miasms are present.

In his *Organon of Medicine* (1810 aphorism 5) Hahnemann refers to ‘exciting causes’ of ill health, such as lifestyle and living conditions, suggesting that these factors may make the patient worse and during treatment may help or hinder healing. Hahnemann was as aware of the need to preserve good health as the need to cure disease. He referred to the need to be “a preserver of health” (Hahnemann 1810: aphorism 4) and the need to be aware of the impediments to good health and the causes of disease.

Long before public health and personal responsibility for health were acknowledged, Hahnemann was concerned about the influence on health of diet, exercise, personal hygiene, sleep, housing and other aspects of lifestyle and living conditions, as well as psychological influences on an individual. Many authors describe Hahnemann as ahead of his time in his concern for public health, his awareness of the germ theory and his understanding of the effect of trauma on health (Castro 1990).

### **1.3.4 The homeopathic remedy**

Homeopathic remedies are made from natural substances which have been diluted and succussed (shaken/vibrated). The more dilute the remedy, the more powerful it is considered to be homeopathically, but in scientific terms the remedies are considered to be inert.

Homeopathic remedies are made from different natural substances, including plant extracts, metals, animal extracts and more recently non-material sources such as electricity. There is also a group of homeopathic remedies called nosodes which are made from disease products eg pus or bacteria, and are used to confer immunity against infectious diseases or overcome the long term effects of such diseases as influenza or scarlet fever. Some countries, such as France<sup>1</sup> have banned the use of homeopathic products of this type (Bhatia 2005).

There are two scales for producing remedies in tablet form, the decimal and the centesimal scale. In both cases the remedy begins as a mixture of the base substance and alcohol, called the mother tincture. For the decimal scale, one tenth of the tincture is added to nine-tenths alcohol and succussed, making the 1X potency. Further dilution and succussion produces higher levels of the remedy, such as the 6X, which has been diluted and succussed six times. The centesimal scale is diluted using one part tincture to a hundred parts of the alcohol solution, creating the C remedies. The chosen potency is then added to the tablets which are made of saccharum lactose, a sugar made from cow's milk. The remedies can also be produced in the LM potency ie 50,000 dilutions, dissolved in mineral water and alcohol and taken as a daily drop.



**Figure 4: A laboratory for making homeopathic remedies 1910 (Wellcome Library, London)**

---

<sup>1</sup> In 1998, the National Agency of Medicines in France prohibited manufacturing, sale, import, or possession of nosodes (defined as human biologicals).



Schmukler (2009) describes what is known about the nature of potentiation of remedies. When a substance in water is diluted and succussed the water molecules form organised clusters and the pattern of these clusters is unique for each substance. He gives the example of common salt diluted beyond  $10^{-7}$  and succussed, in which the molecules form clusters characteristic of salt. At each level of the potentiation process, the pattern is repeated. He compares this to photocopies of a document.

Homeopathic remedies are regulated by the Medicines and Healthcare Products Regulatory Authority (MHRA). A significant landmark in the history of modern homeopathy was the decision by the MHRA to licence the makers of homeopathic remedies to make therapeutic claims for homeopathic remedies. This decision was based on a 2001 European Directive allowing a long tradition of using a medicinal product to reduce the need for clinical trials, if the remedy is plausible on the basis of long standing use and experience (Cohen 2009).

Hahnemann believed that it was essential to reinforce the body's healing response by giving a remedy which is as similar as possible to the symptoms to be healed. He referred to this as 'similia similibus' or 'like cures like'. The remedies are selected on the basis of the symptoms described by the patient. In order to have a positive effect on an individual's health, these symptoms should match the remedy picture obtained from the proving. It is believed that homeopathic remedies which are well selected for the individual activate the body's own healing response. Many patients experience a homeopathic aggravation ie the condition worsens before it gets better, which is considered by homeopaths to be a sign that the body's healing response has been activated. This is similar to the physiological reaction to vaccination. By injecting a small amount of a pathogen into the human body, the innate immune response is activated and antibodies are produced to protect the body. In homeopathy, the response is activated by a natural substance that in a well person would cause the same symptoms as the patient is experiencing.

The central theory of homeopathy is that the remedy must match the symptoms described by the patient or observed by the homeopath. The skills of the homeopath involve gathering relevant information in the homeopathic interview and selecting a remedy to match the needs of the individual case. Homeopathy is a prescription that causes a reaction and it is this reaction that cures the patient. The remedy becomes homeopathic only when it matches the symptoms of the patient (Boulderstone 2009).

“Central to homeopathic philosophy is the belief in the body’s own regulating mechanism that can direct healing – giving a remedy is thought to apply a stimulus to this mechanism.” (Thompson 1999: 38)

### **1.3.5 The homeopathic interview**

“Every case by itself is a new case.” (Schmidt 1921: 7)

Hahnemann (1810) requires specific conduct from the homeopath during the consultation, stating that the patient should first tell his story in his own way and then the homeopath should ask about each symptom in order to elicit more precise information. These follow up questions are designed to find out the individual nature of the symptoms, including when they started, how they feel to the individual, what makes them better or worse and the circumstances at the time of the illness developing. Hahnemann refers to the physician’s role as an observer, noting what he sees in the appearance and manner of the patient. He also requires the homeopath to note the patient’s use of language,

“we should listen particularly to the patient’s description of his sufferings and sensations, and attach credence especially to his own expressions wherewith he endeavors to make us understand his ailments” (Hahnemann 1810: aphorism 98)

Hahnemann described the homeopath as an unprejudiced observer, listening without comment to the patient’s account of illness and matching symptoms to remedies without prejudice or preconceived views.

“The unprejudiced observer – well aware of the futility of transcendental speculations which can receive no confirmation from experience – be his powers of penetration ever so great, takes note of nothing in every individual disease, except the changes in the health of the body and the mind which can be perceived externally by means of the senses.” (Hahnemann 1810: aphorism 6)

This process is also described by Thompson (1999) as the patient setting the agenda, describing their symptoms and lifestyle. The homeopath then explores what is unique about this individual.

“Within the unique story that the patient offers, there may be an apparent trigger to the onset of symptoms from a significant life event. Patients make connections that may be unheard or dismissed by the medical profession.” (Thompson 1999: 37)

Hahnemann believed that the observed effects of diseases implied hidden causes but also that their presentation was unique to each individual. His advice on case taking stresses that the homeopath should look for evidence of what the patient is experiencing, gathering as much detail as possible.

Schmidt (1921) refers to this need to focus on each patient individually and not see them as another case of a particular illness. Each case is different and he expresses the belief that this may make the practice of homeopathy difficult as practitioners may be tempted to repeat a remedy which worked well for another patient with the same illness.

Hahnemann refers frequently to the effect of emotional conflict on an individual. He also showed an awareness of the effect of memory of past experiences on feelings and responses. Clover (1989) compares this with modern perceptions of illness when the ‘unseen energies’ of emotion, thought or personal choice affect our health and well being.

Hahnemann regarded successful treatment as rediscovering healthy function in all aspects of the person’s life. Finding the appropriate remedy to restore this healthy functioning involved considering the totality of symptoms, the external symptoms expressing the inner essence of the disease (Hahnemann 1810). This totality of symptoms can only be

discovered by careful case taking and observation, paying particular attention to the patient's experience of ill health.

The time taken for homeopathic case taking is much longer than is usual for visits to conventional health practitioners (Heiligers et al 2010). The homeopathic interview involves listening carefully to the patient's story and for this reason comparisons can be made with other therapies such as counselling which involve a similar process of talking and listening. The practice of homeopathy, however, does not involve analysis of the patient's story and the patient is not given advice or an action plan based on experiences described in the consultation. In contrast to other therapies involving listening and talking, in homeopathy the patient's story is only used to find the most appropriate remedy to match the symptoms described. There is a particular focus on the language used by the patient and this is not interpreted by the homeopath.

The aspect of the homeopathic interview that is less easy to define is the relationship with the therapist and the impact on the healing process of the patient telling their story. Homeopathy may involve a limited number of consultations and contact at monthly intervals so the building of a therapeutic relationship may be different from other therapies where there is more contact with the therapist. Part of the training of homeopaths involves developing an understanding of the importance of a positive relationship with patients, whilst maintaining the role of the unprejudiced observer. Homeopathic courses also include training in basic psychology and the importance of understanding patient/therapist interaction. Part of the process of this training is designed to define the limits of homeopathy which does not involve psychotherapy or counselling.

Despite the limitations placed on the homeopath, the process of careful case taking and attention to detail in the patient's account of symptoms does offer the opportunity for patients to tell their story and build a trusting relationship with the homeopath. This connection is part of the definition of homeopathy as a complex intervention involving a rapport between patient and therapist. This may have an impact on the willingness of the

patient to tell their story, which may also have a healing effect, as well as allowing the homeopath to select the most appropriate remedy.

### 1.3.6 Remedy reactions

A positive remedy reaction is evidenced by achievement of the aims of homeopathy described in section *1.3.2 Aims of homeopathic treatment*.

If a successful remedy is prescribed, there should be evidence at the follow up consultation of improvement in energy and well being as well as improvement in the identified symptoms (Vithoulkas 1980). Patients may report greater motivation to carry out tasks or self care activities than before taking the remedy, and the ability to manage stressful situations and cope with difficult relationships in a satisfactory manner. Many patients have a history of repeating the same behaviour in difficult situations, but after successful homeopathic treatment they change these repeated patterns of behaviour and as a result achieve more satisfactory outcomes. Espen Braathen cited in Cant and Sharma (1996) refers to this as an ontological transformation which has the power to alter the individual's view of his or her self and also relationships with others. The potentised remedy has the potential to effect life changes as well as symptom relief. The long term effect of homeopathic treatment should be improved health and well being and a greater resilience in coping with future illness or life events (Close reprint 1990).

Hahnemann recorded details of remedy reactions in his *Organon of Medicine* (1810). This was further developed by many well respected homeopaths and specifically George Vithoulkas (1980), who charted a range of remedy reactions. These include:

- ❑ Definite aggravation of symptoms after taking a homeopathic remedy, followed by definite improvement of all symptoms. This indicates that the chosen remedy was the simillimum and no further prescription is required.

- ❑ Marked improvement with little or no aggravation and the patient is better in every respect, which again indicates that the simillimum has been prescribed and the prescription is to take no further action but to 'wait and watch'.
- ❑ Other indications for the 'wait and watch' prescription include improvement in the main health problem but other symptoms are still present.
- ❑ The original problem is better but new symptoms have appeared. This may be an indication that the remedy has activated suppressed symptoms and revealed the full remedy picture. Another remedy would then be prescribed to take account of the new symptoms.
- ❑ The patient was better initially but then symptoms returned. This can suggest the need to prescribe the same remedy at a higher potency.
- ❑ No change in symptoms suggests that the wrong remedy has been prescribed and the case must be taken again and a new remedy given to the patient.
- ❑ Patients who see some improvement but repeated prescriptions fail to achieve long term success may be suffering from an incurable condition or suppression of reaction as a result of the effects of allopathic medicine. Homeopathy can be helpful in palliating symptoms.

These are common reactions in cases of constitutional treatment. Homeopathy can also be used in acute illnesses. The approach and the remedy reaction are different in this type of prescribing. If the patient has an acute illness, a remedy is prescribed based on the current symptoms. These may include both physical and emotional symptoms but take less account of personality and health history. For example, a patient presenting with severe tooth pain and evidence of a tooth abscess might be prescribed Hepar sulph, a remedy known to help infection where there is pus and pain. The patient is also likely to be irritable and feel unwell. The remedy would be prescribed and repeated at intervals of 15 to 30 minutes. If improvement occurs and then symptoms return, the remedy would be repeated until the symptoms disappear. If there is no improvement after three repetitions of the remedy, another remedy would be prescribed (Hayfield 1993).

### 1.3.7 Homeopathy in the UK

Homeopathy is practised in the UK by non-medically qualified (NMQ) homeopaths and medically qualified homeopaths. The Faculty of Homeopaths provides post graduate training in homeopathy to doctors already qualified to practise medicine.

The Society of Homeopaths is the largest professional organization registering NMQ homeopaths in Britain and represents homeopaths who have satisfied the Society of Homeopathy's educational and professional requirements and practice according to their code of ethics and National Occupational Standards for Homeopathy (Ross 2007). Established in 1978, the Society of Homeopaths is the largest body of professional homeopaths. With over 1500 members, it represents 60% of registered homeopaths in the UK. Registered members of The Society of Homeopaths are fully insured and practise in accordance with a strict Code of Ethics & Practice<sup>2</sup>. Two-thirds of homeopathy courses in the UK are formally validated and recognised by the Society of Homeopaths.

The House of Lords Select Committee (2000) listed homeopathy as a group one therapy in its report on complementary and alternative medicine, acknowledging that it has its own diagnostic approach and treatment methods.

“Under The Society of Homeopaths, the non-medical homeopaths have organised themselves well and their professional organisation should mean the transition to statutory regulation does not present too great an upheaval.” (House of Lords Select Committee on Science and Technology, Session 1999-2000: 52)

Several smaller organisations also act as registering bodies for NMQ homeopaths. Recent attempts to create a single organisation to register homeopaths failed and in 2007 CORH (Council of Registered Homeopaths) was dissolved. The Society of Homeopaths is now preparing to apply for statutory regulation of homeopathy in line with other group one therapies.

---

<sup>2</sup> A copy of The Society's Code of Ethics & Practice is available at [www.homeopathy-soh.org](http://www.homeopathy-soh.org)

Homeopathy has been available in the UK through the NHS since 1948. There are five NHS funded hospitals in Bristol, Glasgow, Liverpool, London and Tunbridge Wells. The largest is the Royal London Homeopathic Hospital with an annual budget of £3.5m and treating around 40,000 patients annually (BMA 2007). In his history of homeopathy in Britain, Morrell (2009) refers to the long and distinguished record of homeopathy in Scotland. Many of the greatest homeopaths in Britain have come from Scotland, often based at the Glasgow Homeopathic Hospital.



**Figure 5: The London Homeopathic Hospital 1858 (Google Images 2009)**

Over 400 GP's in Scotland use homeopathy in their everyday practice (Ross et al 2006). Smallwood (2005) stated that if only 4% of GP's were to offer homeopathy as a regular treatment option, a saving of £190 million could be made, as a result of savings in the costs of pharmaceutical drugs. Research carried out by the University of Aberdeen to audit the use of homeopathic and herbal remedies in general practice in the NHS found an apparent acceptance of homeopathic medicine in primary care and extensive use of homeopathic remedies in treating children and babies. In their study of 232 practices, 60% of GP's prescribed homeopathic or herbal remedies in 2003-4 (Ross et al 2006).

The homeopathy market in the UK for 2007 was estimated to be worth £38 million and projected to reach £46 million in 2012 (Mintel 2007). Witt et al (2008) describe homeopathy as increasingly popular and an important factor in public health systems.



They support this view by referring to the expenditure on homeopathy of £3.3 million in the NHS in 2007 and £30.74 million for private treatment.

### **1.3.8 Homeopathy worldwide**

The WHO describes homeopathy as the second largest system of medicine in the world practised in about 67 countries with 300 million users (WHO 2004).

Homeopathy is practised in 40 European countries. It is officially recognised and included in the national health system in European countries such as France and Germany and the United Kingdom (Chatfield 2005). Haidvogl et al (2007) refer to the effective integration of CAM into primary care in most Western countries, with homeopathy being one of the most frequently used treatments. Ong and Banks (2004) found that CAM is typically used for chronic illnesses, particularly for conditions that respond poorly to conventional treatments. Users also refer to the desire for a positive relationship with a healthcare practitioner.

Homeopathy is popular in much of Asia, including Pakistan, Bangladesh and Nepal. About 100 million people in India, out of a population of 1148 million, use homeopathy and the market there is currently growing at 25% annually. Banjerjea (2007) refers to the use of homeopathy in primary care in India, where patients often choose homeopathy in preference to surgery for very serious pathology. He attributes this to awareness of the effectiveness and safety of homeopathy, as well as a family tradition of successful treatment. He also refers to “faith and expectation that the experienced homeopath can and will successfully treat pathology” (Banjerjea 2007: 122). India is the only country which officially recognises homeopathy as the medicine of choice for most of the population. It is also a major source of homeopathic literature and prints homeopathic books which are sold worldwide.

Homeopathy is practised in many other parts of the world, including South America, Australia and New Zealand. In South Africa and the USA there has been political opposition to homeopathy and laws were passed to close down homeopathic colleges<sup>3</sup> (Castro 1990). This has had a significant impact on the development of homeopathy in these countries.

### **1.3.9 The debate about homeopathy**

The origins of homeopathy have already been described, but the history of homeopathy is also a history of conflict and debate. The information in this section is not presented as evidence for or against homeopathy, or as a critical analysis of research into homeopathy. It is included as an indication of the type of debate that has taken place and the context this creates for the publication of future research into the effectiveness of homeopathy.

Hahnemann began the history of debate about homeopathy by rejecting the views of his contemporaries on healing methods and the differences of opinion have continued since then. Dr Hervey Quinn was the first homeopath to become influential in Britain, setting up a practice in London in 1832. He established the organisational infrastructure of homeopathy in the nineteenth century (Nicholls 2005). He was also responsible for the first of many splits in the homeopathic community as he tried to resist the inclusion in the profession of lay homeopaths, in order to protect the integrity of the profession. The divisions in the homeopathic community have persisted throughout its history. The Faculty of Homeopaths, representing medically qualified homeopaths has always operated separately from the bodies regulating NMQ homeopaths and has resisted attempts at co-operation.

An important political landmark for medicine was the Medical Registration Act 1858, which gave medical doctors new rights to practise and made other health care

---

<sup>3</sup> In 1974 an Act of Parliament was passed in South Africa to close down the homeopathic colleges. This was similar to a law passed in the USA in the early 1900's.

practitioners alternative. Complementary and alternative medicine came into existence as a result of this legislation. It was believed that this came about because doctors and apothecaries were trying to protect their livelihood and status. This view has parallels with the current debate which claims that the pharmaceutical companies are funding a campaign to discredit homeopathy and other forms of complementary medicine (Bhatia 2007). This may be an unfounded suspicion but it is included here to highlight the nature of the public debate and the comparisons that can be made between the past and present history of homeopathy.

Publications in the nineteenth century echo the current media headlines about homeopathy. Professor Simpson of Edinburgh University, the founder of the use of chloroform in childbirth, was fiercely anti-homeopathy, and wrote a book called “Homeopathy Misrepresented” (1850) which decried the use of homeopathy. In 1888 a correspondence in the Times newspaper began a heated debate on homeopathy. Other journals and newspapers took up the argument. Over 120 years later homeopathy is still attracting similar critical comment with headlines such as “Homeopathy under fire” (BMA 2007).

Samarasekera (2007) refers to growing pressure against homeopathy in the UK from journalists, doctors and scientists who point to the lack of evidence for the effectiveness of homeopathy. Their public statements about homeopathy have led to calls for the reduction of NHS funding for homeopathic hospitals. In a letter to the Primary Care Trusts (2006) a group of eminent doctors, including Professor Ernst Baum stated that homeopathy, “is an implausible treatment for which over a dozen systematic reviews have failed to produce convincing evidence of effectiveness.” This debate recurs in a wide variety of scientific journals and newspapers, with evidence of strong positions being taken on both sides of the argument. Ross, on behalf of the Society of Homeopaths (2007) refers to the re-hashing of ‘time-worn arguments’ in the Samarasekera article and questions the Lancet’s decision not to include information provided by the Society of Homeopaths in response to questions raised by Samarasekera.

A group of senior doctors including Gustav Born professor of pharmacology at King's College London and Michael Baum professor of surgery at University College, London, wrote to Primary Care Trusts in England demanding that they no longer use public funds to pay for homeopathic treatment (Born et al 2007). Such cuts would have led to the closure of the largest homeopathic hospital in London. Fisher (2007) of the Royal London Homeopathic Hospital wrote a letter to the Guardian newspaper entitled "Open letter, closed minds" in reply to doctors who were critical of homeopathy:

"The doctors who signed today's open letter may find it a bitter pill to swallow, but homeopathy works – and people want it. Homeopathy is enigmatic, remarkably popular, widespread and persistent, despite the scepticism of retired professors of biomedical background." (Fisher 2007)

Jeanette Winterson (2007) refers to the fierce debate between those like her who trust homeopathy because it has worked for them and those who call it, "shamanistic claptrap". She believes that 'homeophobia' is a fear of what homeopathy is suggesting, which is that disease needs to be viewed not as cause and effect, but as a whole picture involving all aspects of the patient's life.

The debate is ongoing. The Science and Technology Committee of the House of Parliament (2010) concluded that the NHS should no longer fund homeopathy. They expressed particular concern about the National Rules Scheme (2006) which allows evidence other than RCT's for medical research. The BMA (2010) have also called for an end to funding of homeopathy in the NHS based on the view that homeopathy is a placebo treatment with no research evidence to support its use. Supporters of homeopathy cite recent research at the Bristol Homeopathic Hospital (2005) into the efficacy of homeopathic treatment and research by Smallwood (2005) into its cost effectiveness, stating that homeopathy costs the NHS approximately £4 million per annum compared to the UK drugs bill of £11 billion per annum (Society of Homeopaths 2010).

The Government response to the Science and Technology Committee report 'Evidence Check 2: Homeopathy' (2010) acknowledges the strength of feeling on both sides of the

debate but confirms the government commitment to supporting informed patient choice and clinical decisions based on patient need and ethical guidelines. This includes the prescription of homeopathic remedies. They note that homeopathy has a long tradition in Europe where it is a recognised and widely used system of medicine and confirm their commitment to following EU guidelines on the regulation of homeopathy.

Research evidence has frequently been used to support the arguments for and against homeopathy in the debate about its effectiveness (Vincent and Furnham 1997). Many research trials have been conducted to evaluate the effectiveness of homeopathy in treating specific symptoms, named diseases and the use of selected remedies. As homeopathy is a holistic therapy which is designed to meet the needs of individuals it is not well suited to controlled trials which focus on a single symptom or remedy. The debate about homeopathy rarely considers the individualistic nature of the treatment. There may be evidence of the effectiveness of homeopathy in research which is not individualised, but it could be argued that this is not a real test of what homeopathy aims to achieve (MacEoin 2006).

The low methodological quality of many research studies into homeopathy has led to them being rejected by academics and scientists, but some studies have been regarded as worthy of consideration. Kleijnen et al (1991) reviewed clinical trials in homeopathy for a wide range of disorders and found that 81 out of 105 controlled clinical trials showed positive effects from homeopathic treatment compared to placebo. Vincent and Furnham (1997) believe that there are many positive results from studies of homeopathy and find it illogical that they are frequently rejected by academics and the medical profession.

One of the most frequently cited trials of homeopathy was carried out by Reilly et al and published in the *Lancet* in 1986. The aim of this trial was to measure the effectiveness of homeopathic remedies in treating allergic rhinitis over placebo. Independent reviewers regarded this as a well conducted trial using rigorous research methods, but its findings in favour of homeopathy were rejected by members of the medical profession. Dr David Reilly changed the direction of his research into homeopathy, because he came to believe

that it was not possible to use research findings for homeopathy as evidence of its value (Reilly 2006).

Despite the evidence for the efficacy of homeopathy there have been powerful presentations of evidence against its effectiveness. The Lancet (2005) published a meta-analysis of 110 clinical trials in homeopathy. The majority of the trials found homeopathy to have a beneficial effect, but the researchers rejected 102 of the trials because they stated that these trials had such positive results in favour of homeopathy that they could not be trusted (Shang et al 2005). Critics of this meta-analysis believe that this is evidence that the researchers viewed homeopathy as implausible and therefore rejected trials that proved it to be extremely effective. Fisher et al (2005) in a letter to The Lancet, state that the conclusions of the study were based on only eight anonymous clinical trials and questioned the selection criteria used in the trial.

Possible arbiters in the debate remain uncommitted. NICE (National Institute for Clinical Excellence) provides guidelines for the use of complementary therapies within cancer care but not patient care in general. The Scottish equivalent, the Scottish Intercollegiate Guidelines Network (SIGN) do not provide guidelines for the use of CAM. Franck et al (2007) question the lack of formal evaluation of complementary and alternative medicine by NICE given its widespread use by the public. Specifically they refer to the possible relevance of CAM therapies for patients with chronic illnesses, who account for 80% of GP consultations. They suggest that lack of evaluation by NICE may be related to problems with research methodology, bias against CAM or lack of resources.

The debate about the efficacy of homeopathy creates a climate of negativity and bias that makes it difficult to present new research evidence relating to homeopathy. The antagonism experienced by researchers has led some to avoid publication of new evidence, feeling that the hostile climate will automatically lead to their research being dismissed or decried (Reilly 2006). The following section *1.4 Research Perspectives on Homeopathy* shows the range and quantity of research into different aspects of homeopathy and attempts to evaluate some of the more recent research, whilst

acknowledging that much of the research is now dated and does not take account of new approaches to researching holistic therapies.

## 1.4 RESEARCH PERSPECTIVES ON HOMEOPATHY

This section will review the research evidence currently available for homeopathy by considering:

- ❑ research issues relating to CAM and homeopathy
- ❑ research into the action of the homeopathic remedy
- ❑ research studies into the efficacy of homeopathy
- ❑ the choice of methodology for homeopathic research studies

### 1.4.1 Evidence based medicine and homeopathy

Evidence based medicine drives the current need for valid and reliable research into all healthcare interventions. The number of CAM trials has increased significantly in recent years, as has the number of meta-analyses of CAM research. Most CAM research has used the same approach as clinical pharmacology. In this approach the aim is to establish a drug as safe and effective in order to satisfy government regulations and the requirements of those who fund conventional health care. CAM therapies do not have similar financial gatekeepers and the research needed to provide the required evidence base is therefore limited (Fønnebø et al 2007). Dr Sara Eames (2007) cited in the *bma news* refers to the lack of commercial drivers for homeopathic clinical studies which prevents doctors from taking part in expensive and time consuming research.

The requirement for evidence based medicine has put pressure on complementary medicine to provide proof of safety and efficacy in trials that match those carried out for drug therapies (Greenhalgh 2000, Smallwood 2005). Randomised controlled trials (RCT's) have become the accepted method of researching health treatments.

“It is now well established that the evaluation of interventions (such as drug therapies, surgical operations or complex educational or behavioural treatments) should be undertaken as far as possible by means of double-blind randomised controlled trials.” (Greenhalgh 2000: 59)



This emphasis has made it very difficult to get appropriate evidence of the efficacy of complementary medicine. The holistic experience of CAM users is not well covered by the pharmacological approach to researching efficacy of drugs, which involves using RCT's and focusing on the action of a specific agent on specific symptoms. Shang et al (2005) reporting on the placebo effect and homeopathy conclude that placebo-controlled trials of homeopathy should be replaced by research which focuses on 'context effects'.

Verhoef (2005) refers to the limitations of RCT's when researching the effectiveness of CAM. These include the individual nature of CAM treatments and the general nature of the conditions being treated. It can also be difficult to recruit randomly because of participants' beliefs and preferences. Although this is true for most research, it can be a particular issue in CAM research, if the participants are predisposed to believe in the efficacy of CAM. An RCT is also unable to give information about whether a treatment worked in ways other than those expected or in different ways for individuals. Outcome measurements do not address all the potential benefits of CAM interventions, particularly the effect of the therapeutic relationship and the focus on individual and holistic health issues during treatment. RCT's also study interventions in isolation whereas most CAM treatments are part of a process which includes the setting, the therapeutic relationship and the patient's own contribution to the healing process. RCT's assess whether an intervention has a statistical effect, but there is no investigation of why an intervention works and how participants experience the process of healing. Haidvogel et al (2007) conclude that placebo-controlled RCT's are highly standardised and therefore create artificial treatment situations which are very different from daily practice in health care.

The real difficulty for homeopathy in taking part in randomised testing is that such testing is not based on the needs of the individual and is not often holistic in intent. These are key aspects of homeopathic philosophy.

“The randomised clinical trial is designed to produce generalisable knowledge about the standardised effects of a particular intervention which can be regarded as true of all populations at all times, the antithesis of the local knowledge of a specific body with all its individual peculiarities.” (Sharma 1996: 170)

There is growing evidence that CAM research requires different approaches from those used for testing conventional medication. Studies of homeopathy using RCT's which provide evidence that the homeopathic remedy is more effective than placebo have frequently been rejected because of methodological weaknesses, or lack of belief in the mode of action of homeopathic remedies.

Richardson (2005) refers to the first person evidence constructed by the user of CAM based on personal experience, which is as valuable as information gained from randomised controlled trials and evidence based medicine. She supports the use of both quantitative and qualitative methods of researching CAM:

“...even very sophisticated RCT's, may fail to detect the complexity of factors which lurk in the swampy lowlands of the consultation and contribute to the outcome.” (Richardson 2005: 30)

This view is supported by Enderby (2007), who believes that mixed methodology ie quantitative and qualitative research, is required to provide a different angle on the same truth. She believes that Cochrane reviews are too simplistic, often rejecting trials which have value but show a negative outcome. She also regards meta-analyses as too simplistic, ignoring causal connections. In her view triangulation of research methods both collects data and seeks explanations for information gathered.

The increasing complexity of health service provision has encouraged the search for new ways of carrying out research. Pope and Mays (1995) note the difficulty of applying the findings of randomised controlled trials in daily clinical practice. They value qualitative research which makes use of lay and professional health beliefs and accesses information about areas that have received little previous investigation. The more recent requirement for evidence based medicine has placed even greater emphasis on the results of RCT's in determining treatment practice, particularly in the NHS, and less value on other research methods, thus creating a dilemma for researchers who believe that other approaches to CAM research are more valuable.

There has also been an increase in patient centred outcome measures in the social science field. Outcome measures do not yet exist for some health concepts and individualized, patient centred outcomes can be hard to quantify in research terms. Nine outcome domains have been identified by Verhoef et al (2006): physical, psychological, social, spiritual, holistic, quality of life, individualised measures, context of healing and process of healing outcomes. They also highlight the importance of process and the context of an intervention, including the therapeutic relationship. These aspects of CAM research are complex and sometimes impossible to measure accurately. The requirement for evidence based medicine creates a dilemma for the CAM researcher when selecting research methods.

Homeopathic treatment involves prescribing a remedy for the individual not for the symptom or disease they present with. This means that it is not possible to consistently control the variables in homeopathic treatment. Current literature on homeopathic research suggests that different research approaches are therefore required in order to assess the outcomes of treatment, using both quantitative and qualitative research methods.

### **1.4.2 Research into the action of the homeopathic remedy**

There has been no satisfactory explanation for the effect of homeopathic remedies on health problems, other than placebo. However, some scientists have suggested that water can retain an imprint or memory of substances dissolved in it (Schmukler 2009).

This mechanism was tested in a trial carried out by Jacques Benevise (1988) in which he provided the explanation that the water in which the homeopathic substance was diluted had a memory and this imprinted memory provided the cure, even when there was no measurable trace of the original substance. Benevise lost his funding and international credibility as a result of publishing this research. A pan European team led by Professor

Ennis tried to discredit the research further, but have only succeeded in suggesting that Beneviste might have been right (Matthews 2006).

More recently, Rustum Roy a materials scientist at Pennsylvania State University described the rejection of Beneviste's idea as naïve and simplistic, arguing that water has proved itself capable of effects that are extremely complex (cited in Matthews 2006). He refers to an effect called epitaxy ie using the atomic structure of one compound as a template for producing the same structure in others. Roy also refers to the shock waves generated in the succussion process which may trigger fundamental changes in the properties of the water molecules.

Bellavite et al (2007) explored the concept of the homeopathic 'simile' in their series of lectures on immunology and homeopathy. They define the 'simile' as the principle that a homeopathic remedy given to a healthy subject will produce a set of symptoms which the same remedy will cure in someone who is unhealthy. They assert that Hahnemann's theory of the simile has been supported by scientific findings in different fields, including immuno-allergology, the study of immunity and allergic reactions. They refer to the Kleijnen et al (1991) review of homeopathic trials which concluded that there was a surprising amount of evidence that homeopathy is effective, but they found the mechanism of action implausible. This concern is based largely on another key principle of homeopathy which is the dilution and potentisation of homeopathic remedies. Bellavite et al (2007) assert that even high dilutions of the simile can incorporate structural or frequency information which simulate the disorders of natural disease and contain complex information which can promote healing.

“Homeopathic therapy should act by regulating the inflammatory and immune systems, both directly through molecular similarity, as seen in isopathic therapies, and indirectly through systemic interconnections.” (Bellavite et al 2007: 152)

Bellavite et al (2007) also refer to the role of stress in suppressing the immune system and causing internal communication failures leading to chronic disease. Homeopathic

information mimics patho-physiological stress and re-activates a coherent response in the organism, as shown in the research study on mice carried out by Bousta et al (2001). They subjected mice to stress and noted the behavioural, immunological and gastric changes which resulted from the application of foot shock. They then went on to evaluate the use of homeopathic remedies and found that they had a significant immuno-protective and gastro-protective effect in mice exposed to this experimental stress.

Bellavite refers to the effect of dissolving homeopathic remedies in water or water and alcohol, stating that studies have shown the effect of ‘water clusters’, dynamic self organising networks which activate biological processes on the cell membrane level.

“Our belief is that many ‘high dilution’ experiments point out elusive physicochemical and biological phenomena that really occur in nature, associated with the structural and dynamic properties of water and water/alcohol solution, but they are difficult to reproduce in laboratory settings.” (Bellavite et al 2006: 19)

“Thus, a homeopathic drug might be regarded as a small quantity of matter in which phased oscillating elements could coherently transmit, oscillatory frequencies, via resonance, to both oscillating and non-linear biological fluids or complex ‘metastable’ structures (macromolecules, protein different conformations, membranes, filamentous structures, receptors).” (Bellavite et al 2007: 160)

Milgrom (2003) believes that biomedicine’s reductionist paradigm limits the potential for exploring the scientific basis for the use of homeopathy by making a flawed comparison with the effects of pharmacological medicines. He refers to the work of Benevise and Ennis on the memory of water and their most recent theory that it may be possible to ‘format’ water in a way that could be compared to formatting floppy discs for computers. However, Milgrom views the memory of water theory as focusing on the physical action of the remedy and ignoring the other ingredient in homeopathy which is the “healing interaction between consenting human beings that ultimately gives rise to the remedy” (2003: 11). He refers to the theory of entanglement, a view of the world which sees everything as inextricably linked to everything else. Homeopathy is a process, dependent on the order in which things are done.

“A remedy can be considered homeopathic when its locality, as defined by preparation and potency, becomes entangled with the non-local therapeutic interaction between the patient and the practitioner; the triadic totality curing the case.” (Milgrom 2003: 13)

The studies carried out by these scientists suggest that ongoing research may eventually provide a scientific explanation for the mechanism of action of the homeopathic remedy. The development of nanotechnology and nanopharmacology may focus attention on the minimum dose as scientists consider the potential of the tiniest particles of matter (Ullman 2010).

The lack of understanding of the mechanism of action of homeopathic remedies is often cited as a reason for dismissing the evidence of outcomes of treatment, therefore any research which gives further insight into the way homeopathy works increases the value of research into clinical uses of homeopathy.



Figure 6: Cartoon mocking diluted homeopathic remedies ([www.ntskeptics.org/cartoons/weekly](http://www.ntskeptics.org/cartoons/weekly) )

### **1.4.3 Research studies of homeopathy and CAM**

Research studies into homeopathy and a range of CAM therapies have been carried out for many health problems. Extensive evaluation of this research has resulted in considerable controversy. The purpose of this section is to present an overview of the research that has already been carried out in order to confirm the quantity and diversity of the research into homeopathy, but also to show that the aims of this study have not yet been met by other research studies. There is little published research into the use of homeopathy as a complex intervention or into its use for the 55+ age group.

Some recent studies provide useful information about the approaches used in homeopathic research and a more detailed evaluation of these studies has been carried out in section *1.4.3.2 Evaluation of recent research studies*.

Another source of information about the action of the homeopathic remedy is the research carried out on animals. Because the focus of this study is on homeopathy as a complex intervention this overview does not include any evidence from animal studies but it is acknowledged that animal research provides another perspective on homeopathic treatment.

#### **1.4.3.1 Overview of research into homeopathy and CAM**

Selecting homeopathy research evidence for review purposes is complicated by the debate discussed in section *1.3.9 The debate about homeopathy*. The strength of debate surrounding published work on homeopathy can make it difficult to be objective when evaluating the research as many eminent researchers present convincing cases for and against homeopathy. An additional difficulty is that CAM research papers are often published in specialist journals that are less well known and less likely to be peer reviewed by experienced researchers. It can also be difficult for researchers of CAM to

fund and carry out research that meets the standards required for publication. Additionally, research carried out by individual homeopaths can lack independent verification of methodology and results.

In a memorandum to the UK Parliament the Complementary Medicine Research Group of York University summarised these difficulties in the following statement:

“Although there is an increasing body of trials available, the lack of independent confirmation of reported trials and the presence of conflicting results is a major limitation to homeopathy research. Furthermore the general field is bedevilled by the lack of well-designed replicable studies conducted by independent research teams. Two key factors inhibiting current and future homeopathy research are the lack of adequate funding and lack of well-trained homeopaths who are sufficiently qualified and interested in engaging in objective research.” (2010)

For those researchers who do attempt to carry out rigorous research there is a real difficulty in identifying methodology that meets the requirements of the research community. Homeopathy is an individualised and holistic method of treatment which is less well suited to research methods which focus on specific symptoms, illnesses or homeopathic remedies. Despite this difficulty many researchers have attempted to capture the experience of homeopathic treatment in research studies. By the end of 2009, 142 RCT's comparing homeopathy with placebo or conventional treatment had been published in peer reviewed journals. 63 of these studies were able to draw conclusions in favour of homeopathy and 11 were negative (Memorandum to the UK parliament, the British Homeopathic Association 2009).

Much of the research on homeopathy is presented in libraries and journals dedicated to the presentation of CAM or homeopathy research. The Society of Homeopaths website now includes open access to information about research, but this was formerly available only to members of the Society (The Society of Homeopaths, Evidence base for research 2010).



Research presented in other forums is often restricted to specific types of research or focuses on specific illnesses. An example of this is the 2010 Annual Evidence Update on Homeopathy (NHS Evidence – Complementary and Alternative Medicine 2010) which lists eight RCT's published in English in the previous year. Some research topics are very specific in nature, such as the homeopathic treatment of minor aphthous ulcer, but others are more general, such as the treatment of chronic insomnia with the homeopathic simillimum.

Some Cochrane reviews have been carried out for specific uses of homeopathy:

- ❑ Homeopathic medicines for the adverse effects of cancer treatments – eight studies were reviewed with a total of 664 participants. Four studies showed benefits from the use of homeopathy and it was recommended that the trials were replicated.
- ❑ Homeopathy for attention deficit/hyperactivity disorder – four studies were reviewed. No evidence was found that homeopathy was effective in relieving symptoms of attention deficit disorder.
- ❑ Homeopathy for chronic asthma – six studies were reviewed with a total of 556 participants. No recommendations were made as the type of homeopathy used in trials varied. The individualised nature of homeopathy was noted, which made it unlikely that research trials could replicate common homeopathic practice.
- ❑ Homeopathy for induction of labour – the review of two trials found that there was not enough evidence to recommend homeopathy but expressed the view that more research is needed.

The Cochrane Reviews consider a limited number of research studies into the effectiveness of homeopathy for specific conditions. Their conclusions make reference to the individualised nature of homeopathic prescribing and the likelihood that research trials may not measure the 'package of care' effect. This package includes the remedy and the consultation, which they describe as a vital part of homeopathic practice.

The European Network of Homeopathy Researchers (ENHR) has produced a summary of research that provides evidence to support the use of homeopathy. The ENHR consists of 66 individuals from 15 different countries involved in homeopathy research and is supported by the European Council for Classical Homeopathy. The ENHR summary of research is presented in the UK by Chatfield and Viksveen (2007) and published by the Society of Homeopaths (See Appendix 16).

The ENHR studies are categorized under the following headings:

- ❑ Use of homeopathy and other CAM therapies (13 studies)
- ❑ User surveys of patient satisfaction with homeopathic treatment (12 studies)
- ❑ Safety of homeopathic treatment (1 study)
- ❑ Reviews and meta-analyses (11 reviews and meta-analyses)
- ❑ Key trials and surveys:
  - Diarrhoea in children (3 studies)
  - Respiratory tract complaints (7 studies)
  - Musculo-skeletal problems (4 studies)
  - Hay fever, asthma and perennial rhinitis (4 studies)
  - Pre-menstrual syndrome (PMS) (2 studies)
  - Menopausal complaints (3 studies)
  - Homeopathy after oestrogen withdrawal (1 study)
  - Hot flashes after breast cancer therapy (4 studies)
  - Infertility (1 study)
  - Sperm quality (1 study)
  - Pregnancy-related problems (1 study)
  - Attention Deficit Hyperactivity Disorder (ADHD) (2 studies)
  - Chronic Fatigue Syndrome (2 studies)
  - Surgery (1 study)
  - Dengue haemorrhagic fever (1 study)
- ❑ Cost benefit (5 studies)
- ❑ The effect of high dilutions (6 studies)
- ❑ Treatment of animals (3 studies)

The ENHR summary attempts to show the range of research into homeopathy. The benefit of the summary is that it provides an overview of past homeopathy research studies, but it also shows the emphasis on treatment of symptoms and named illnesses,

rather than treatment of the individual. It includes studies that evaluate homeopathy as one of several CAM therapies which can give a distorted view of results as CAM therapies use different approaches and view outcomes differently. The individualized nature of homeopathic treatment is also difficult to capture using reviews and meta-analyses. The ENHR summary of homeopathy research does not include research into homeopathy as a complex intervention or for the 55+ age group. (See Appendix 16)

Van Wassenhoven (2008), a prominent member of the homeopathic research community and founder of the European Committee for Homeopathy and Research, also conducted a comprehensive review of homeopathic trials.

He included in his review the following meta-analyses:

- ❑ 105 studies considered by Kleijnen et al (1991) in which 77% show positive results for homeopathy
- ❑ 15 studies considered by Boissel et al (1996) in which he believed the results could not have been attributed to placebo alone
- ❑ 89 studies considered by Linde et al (1997) in which he again concluded that the evidence could not be attributed to placebo alone
- ❑ 32 studies considered by Linde and Melchart (1998) in which an individualised approach to homeopathy was used and results were more significant than with placebo alone
- ❑ 16 trials considered by Cucherat et al (2000) showing evidence of the positive effects of homeopathy
- ❑ 110 trials considered by Shang et al (2005) with evidence of positive outcomes

Van Wassenhoven used the same approach as the ENHR survey including past evidence of homeopathy research based on trials that used the same methodology as pharmacological trials. None of these trials described homeopathy as a complex intervention taking account of both the remedy and the interaction with the therapist.

As the ENHR summary of homeopathy research shows, studies of CAM often include homeopathy and results are frequently amalgamated rather than presented for separate therapies. In a recent pilot project evaluating the use of CAM in two primary care centres in Northern Ireland results for homeopathy were presented separately. Researchers reported an improvement in physical health in 81% of participants (713 participants took part) and 79% in their mental health (McDade 2008). There was a high degree of correlation between GP and patient assessment of health. Other positive benefits identified included less use of medication, fewer visits to GP and outpatient clinics and less anxiety about health among participants. Participants who received homeopathic treatment reported an average 54% improvement in their health and well being. Data was collected using MYMOP questionnaires and patient interviews. The use of mixed methodology and different perspectives on the outcomes makes this type of trial more relevant for the assessment of outcomes of homeopathic treatment.

Most of the published research into the effectiveness of homeopathy has studied specific health problems or a general population presenting with a variety of illnesses (Damoiseau et al 2000, Pilkington et al 2005, Taylor et al 2000). There is little research into the effectiveness of homeopathy for the 55+ age group and limited consideration of the complexity of individualized homeopathic treatment.

#### **1.4.3.2 Evaluation of recent research studies into homeopathy**

Much of the research included in the overview was carried out more than ten years ago and the focus was frequently on research techniques used in trials of pharmacological medicines. These approaches continue to be used in CAM research but consideration has also been given to new approaches to measuring health outcomes.

Three recent studies of homeopathy have been selected for specific evaluation because they have some relevance to this study:

- ❑ A 6-year, university-hospital outpatient observational study carried out in Bristol to review homeopathic treatment for chronic disease (Spence et al 2005) using the MYMOP questionnaire to record outcomes for individuals in the study
- ❑ A study to compare the use of homeopathy and conventional treatment in acute respiratory and ear complaints (Haidvogel et al 2007) using an RCT model to research specific symptoms, which is a direct contrast with the more holistic models of CAM research
- ❑ The use of homeopathic treatment for elderly patients in Germany and Switzerland (Teut et al 2010), one of the few studies to focus on older people and also consider quality of life using the SF-36 health survey

The 6-year, university-hospital outpatient observational study carried out in Bristol was designed to review homeopathic treatment for a range of health problems (Spence et al 2005). It addressed the question of the effectiveness of homeopathic remedies in treating chronic ill health. It involved 6544 patients and 70% (n = 4627) of them reported improvement in symptoms in MYMOP questionnaires. All patients attending the outpatient unit for follow up appointments over the study period were included in the research.

Patients in this study had already made a choice to have homeopathic treatment by attending the hospital but because all patients were included there was less risk of patients self selecting to take part in the research and less risk of bias as a result. The Bristol study was a very large study, carried out over several years. The researchers' aim was to monitor the 'real world' effectiveness of homeopathic treatment rather than carry out a randomised controlled trial. The size of the study and the use of the 'real world' approach increased the validity of the results in homeopathic terms.

The outcomes of the Bristol study compare well with other similar trials. The findings are similar to those found in studies carried out at the Tunbridge Wells Homeopathic Hospital in 2000 (Clover 2000) where 74% of 1372 patients reported a positive result

from homeopathic treatment, and the Liverpool Department of Homeopathic Medicine (Richardson 2001), where 76% of 1100 patients also reported an improvement in their condition. The Bristol study was also independently reviewed by the Consumer Involvement Unit of the hospital on two occasions and they confirmed that patients reported improvements in their health.

It could be argued that a limitation of the study is that it was carried out by different doctor homeopaths, 12 in total, and therefore consistent approaches to treatment were less certain. However, this may be less of a problem in such a large study. The study involved treating different conditions and all age groups but most participants were less than 48 years old. Greater improvements were recorded in children. This is a common outcome in homeopathic treatment, possibly because children have less serious health problems and can make overall results seem more positive (Trichard 2005).

The MYMOP questionnaire used in the Bristol study is favoured by CAM researchers because it is patient centred. Individuals choose their own symptoms, which they then score on a scale of 1 to 6 over a period of time. The stated aims of the study were to enhance general health and well being as well as to improve symptom control. MYMOP includes one question on well being but deals mainly with patient selected symptoms. It is not a holistic measure of health improvement and does not record any additional benefits of homeopathic treatment such as improvement in energy and emotional well being. Evidence of these outcomes is more likely to be found if mixed methodology is used, including qualitative data.

Haidvogel et al (2007) carried out a study to compare the use of homeopathy and conventional treatment in acute respiratory and ear complaints. This study was an international, multi-centre study focusing on acute treatment of respiratory and ear infections. It involved 57 primary care practices in different countries including USA, United Kingdom and Russia. 1577 patients were monitored, 857 receiving homeopathic treatment and 720 receiving conventional treatment. Patients were monitored by researchers over a 14 day period. It was noted that the onset of improvement was faster in

both adults and children receiving homeopathic treatment. The outcomes for both types of treatment were similar leading to the conclusion that homeopathic treatment is not inferior to conventional treatment and can lead to more rapid recovery. The comparison of conventional treatment and the use of homeopathy is favoured by some CAM researchers, rather than comparisons with placebo (Complementary Medicine Research Group, University of York 2010).

The authors of this study refer to the limitations of RCT's resulting from highly standardised study protocols and patient populations, thus not representing the general population. Another limitation of their study is that patients chose the method of treatment they preferred and often had a strong preference for homeopathic treatment. There is also possible bias resulting from patients assessing their own recovery, using a scoring system, rather than using independent means of determining outcomes of treatment, however the use of a specific date when patients felt better may be regarded as more objective evidence of successful treatment. In this study it would have been possible to use observational means of assessing improvement to support patient perceptions. The study also focused on self limiting health problems which frequently resolve spontaneously in the 14 day period allotted by the study team. The use of an international research team can add credibility to findings, but may also have made it more difficult to standardise research procedures.

Like much of the research into homeopathy in the past, Haidvogel et al (2007) have used research methods which are regarded as the 'gold standard' of pharmacological research. Although this is a credible way of gaining evidence for a treatment intervention, and attempts to align CAM therapies with conventional treatments, these research methods are less useful for CAM therapies, particularly those like homeopathy that use individualised methods of treatment. Symptom and disease based studies like this one focus on changes relating to specific symptoms or illnesses and fail to capture the other aspects of holistic treatment, such as improvements in energy or well being, and longer term resilience or freedom from symptoms.

A recent study by Teut et al (2010) into the use of homeopathic treatment in elderly patients investigated homeopathic practice in Germany and Switzerland. The study included 3981 patients over the age of 70 consulting a homeopathic doctor for the first time. Outcome measures included a numeric rating by patients for the severity of symptoms, SF-36 for quality of life and a physician numeric rating for severity of diagnosis. Initial results were presented for a sub group of 83 adults aged over 70. The severity of complaints decreased significantly over the 24 months of treatment on both patient assessment ( $p < 0.001$ ) and physician assessment ( $p < 0.001$ ) but quality of life and number of medicines taken did not change significantly but remained stable.

This study was carried out by several different homeopaths, all using classical homeopathic principles, but free to use other treatments, including conventional medication, and any homeopathic remedy depending on symptoms and diagnosis. Patients were included in the study regardless of their diagnosis. This lack of selection criteria and broad approach to treatment makes it more difficult to assess the value of homeopathy specifically and patient scores were inevitably subjective, but there is evidence of improvement from both patients and physicians. Teut et al (2010) conclude that further similar research would be useful to assess the potential value of homeopathy for treating elderly patients.

These studies consider different aspects of homeopathic treatment, in different circumstances, which provides valuable information about appropriate research methodology for future trials of homeopathy. They also highlight the limitations of different approaches to research and the real difficulty in evaluating the use of holistic and individualised therapies like homeopathy.

In summary:

- ❑ Much of the research into the use of homeopathy has been reviewed repeatedly to establish its rigour in research terms and to establish whether there is real evidence of the effectiveness of homeopathy. The opposing views of eminent



researchers and clinicians make it difficult to draw conclusions from this evidence.

- ❑ Homeopathy is a therapy involving individualised treatment. Evidence is often based on the perceptions of participants in research trials about their health and well being. Generalising results from a homeopathy trial can be difficult as individuals experience homeopathy, illness and recovery in different ways.
- ❑ The methodology chosen for research into the effectiveness of homeopathy has to take account of the individualised nature of the therapy and the requirements of evidence based research. These requirements may be incompatible and part of the debate about research into homeopathy may be related to the difficulty in providing rigorous evidence which takes account of individual experiences.

#### **1.4.4 Current research methods for evaluating homeopathy**

“CAM is not simply a new array of therapeutic tools that need to be evaluated; it presents other ways to think about disease and therapeutics, and consequently new ideas about how research should be strategically developed.” (Fønnebø et al 2007)

As the demand for evidence-based medicine increases so do the demands for scientific evidence of the benefits of homeopathy (Chatfield 2006). Meta-analyses and RCT's are currently placed at the top of the research hierarchy in order to synthesise large amounts of clinical data and offer apparently objective criteria for treatment choices and funding decisions.

Chatfield (2006) believes that this amalgamation of trials of different homeopathic practices means that homeopathy is not evidenced appropriately. The lack of funding for research means that the type of studies required to provide further meaningful evidence for the Cochrane Library is not available. She also states that research that has taken place shows that homeopathy is not well suited to placebo-controlled trials and other methodologies are required. This challenges the positivist view that scientific questions

can be settled by observation and experimental testing to ascertain the facts. In her opinion, the acceptance or rejection of evidence of any sort is ‘value-laden’. There is a natural tendency to reject evidence which does not fit currently held theories, and therefore even the most rigorous RCT’s in homeopathy will be rejected by those who have difficulty believing in the effect of highly diluted remedies (Chatfield 2006). Evidence may support many and even contradictory theories, as shown in the varying interpretations of existing research into the effects of homeopathy.

MacEoin (2006) believes that scientific research which demonstrates that homeopathy is merely placebo is based on false premises. His view is that homeopathy as it really exists has never been tested. The clinical trial is unsuited to testing homeopathy, because it is too blunt an instrument to handle sophisticated and individualised homeopathic treatment, including multiple remedy choices and changes from one remedy to another, changes of potency of remedies and periods of waiting without further prescription.

This view is supported by Thompson and Weiss (2006), who believe the comparison between placebo and non-placebo arms in homeopathic trials does not constitute a fair test as the remedy cannot be separated from the consultation process. RCT trials involving placebo are therefore regarded as less suitable for research into the effectiveness of homeopathy.

Weatherley-Jones (2004) believes that there is a fundamental problem in interpreting placebo controlled trials in homeopathy. She states that it is not reasonable to assume that the specific effects of homeopathic remedies and the non-specific effects of the consultation act independently.

These views challenge the way that homeopathy is currently evaluated in research trials and call for new approaches to research.

### **1.4.5 Researching homeopathy as a complex intervention**

The Medical Research Council (MRC) define complex interventions as health interventions with several interacting components (MRC 2000). The guidance for researchers of complex interventions provided by the MRC was updated in 2008 to include interactions between components, the number and variability of outcomes and the degree of flexibility in tailoring interventions for individuals.

Using this definition, homeopathy can be categorised as a complex intervention. It includes taking a remedy, the therapeutic relationship, patients' beliefs about healing, the effect of describing and appraising their own story and the effect of any self care implemented as a result of the homeopathic consultation.

The MRC (2008) are clear that researching a complex intervention presents specific challenges in terms of both choice of methodology and design and delivery of the research. To overcome some of these issues the MRC (2000) produced a five phase framework for research into complex interventions. This was an attempt to rationalise research which seeks to evidence the use of a range of therapeutic approaches.

The MRC provide a sequential framework to be applied in researching complex interventions.

- ❑ Pre-clinical – theory
- ❑ Phase I – modeling
- ❑ Phase II – exploratory trial
- ❑ Phase III – definitive RCT
- ❑ Phase IV – long term implementation

All the MRC phases have been used separately in homeopathy research, but homeopathy has not previously been defined as a complex intervention according to Thompson et al (2006). They believe that individualised homeopathy suffers in the context of a placebo-

controlled trial because it is a complex intervention with many potential non-specific effects. They attempted to discover the active ingredients in the homeopathic process during a research study at the Bristol Homeopathic Hospital. They highlighted unique aspects of the homeopathic process, such as the remedy matching the individual's symptoms and story (Thompson et al 2006).

Walach et al (2006) also find the MRC model inadequate for the evaluation of complex interventions, including CAM.

“If we take into account the context dependence of therapeutic effects, it is clear that each study creates its own universe of applicability which in the best case is an abstraction and in the worst case is a distortion of the real world of clinical practice.” (Walach et al 2006: 6)

The MRC model is based on a hierarchical perspective which provides successively more rigorous evidence of outcomes of treatment. Instead of this evidence hierarchy, Walach et al (2006) propose a circular model, arguing that there is no single ideal methodology. By triangulating a result achieved with one method and replicating it with other methods, they expect to provide a more comprehensive evidence base, as the strengths and weaknesses of different research methods counterbalance one another. “A composite of all methods constitutes best scientific evidence.” (Walach et al 2006:6) They refer to the Gabbay and Le May (2004) study of clinical decision making in general practice which was found to be based on a combination of evidence based medicine, clinical experience, patient needs and preferences, and peer group advice. They also refer to the incidence of patients recovering for complex reasons that cannot be isolated in controlled trials. Such experiences can only be captured with qualitative data. The circular model includes experimental methods that test for efficacy which are complemented by non-experimental methods that are more descriptive including context and real life experiences.

Campbell et al (2000) also conclude that complex interventions should be evaluated using both quantitative and qualitative evidence. In their view, a complex intervention should be evaluated as a therapeutic process rather than attempting to isolate the effects of a

remedy. Yardley (2008) refers to the need to establish validity in qualitative research. She refers to triangulation as a method of enriching understanding of experience by viewing it from different perspectives. Campbell et al (2000) conclude that complex interventions should be evaluated using both quantitative and qualitative evidence. They believe that qualitative research can be used to show that an intervention works, but can also go on to identify potential barriers to change in both patient and professional behaviour.

Boon et al (2007) investigated different approaches to research methods for complex health interventions, including the MRC framework. They conclude that the systems have many similarities, although different terminology is used, and all acknowledge the need for alternatives to the classical pharmacological approach to health research used in the RCT model. They refer to complex interventions as those that pose the greatest difficulty when trying to define the ‘active ingredients’. Boon et al (2007) refer to the requirement for broader research perspectives for complex treatment systems than can be provided by methods used to research single component interventions.

Research into the effectiveness of homeopathy has focused on the effect of the remedy on health outcomes. The homeopathic consultation and discussion of self care issues are part of a package of treatment that accompanies the remedy. This is a complex intervention which should be evaluated as such, using both quantitative and qualitative data in order to record as clearly as possible the outcomes of homeopathic treatment.

## CHAPTER 2: METHODOLOGY

### 2.1 INTRODUCTION

This chapter includes information and analysis of:

- ❑ the aims and research questions for the study
- ❑ the philosophical assumptions that underpin this study
- ❑ the research study design
- ❑ the research study methods

The study aims to answer the following questions:

- ❑ Is homeopathy perceived to be effective in improving health and well being and quality of life in the 55+ age group?
- ❑ What are the common themes in the experience of homeopathic treatment described by participants in this study?

The review of literature on existing research into homeopathy identifies significant challenges in responding to these research questions. Homeopathy is a holistic and individualised approach to health care which can be difficult to evidence using the preferred approaches in evidence based medicine, RCT's and meta-analyses. The chosen population for this study is also diverse in age, life experiences and symptomology. The research questions require the measurement of perceptions of healing and this inevitably includes subjective responses which are difficult to generalise across the study cohort and to the wider 55+ population. The following rationale for the methodology chosen for this study attempts to explain how these challenges will be met.

## 2.2 PHILOSOPHICAL ASSUMPTIONS FOR THIS STUDY

This study is based on a pragmatic world view which is problem centred and oriented towards what works in practice. Pragmatism takes account of both biased and unbiased perspectives and combines different methods of data collection, valuing both objective and subjective knowledge (Creswell et al 2008). This is a relatively new approach to research, in which the research question is of primary importance, rather than the method or the philosophical world view underlying it. The pragmatic view focuses on practical, applied research which informs methodological choices. The research methods chosen are therefore deemed to be practical and workable in the context of the study. This may result in ideas and arguments which cannot be reconciled. Creswell (2008) notes that although there may be contradictions and oppositions which are not reconcilable, they reflect different ways of knowing about and valuing the world we live in. Information that appears to be biased is dealt with by recognising and acknowledging the bias.

Pragmatism is an epistemology which views reality as characterised by change and open to multiple interpretations. Meaning emerges through practical actions taken to solve problems. Facts and values are linked and truth is provisional. Pragmatism addresses the active processes through which we create meaning, suggesting that people construct reality through interaction. These processes arise out of action and in turn influence action. The homeopathic consultation can be seen as an example of this social interactionism, as individuals tell their story and find meaning in their recollections of significant life experiences.

Different philosophical assumptions highlight the relevance of pragmatism to this study. Positivism is an epistemology based on objective and systematic observation and experimentation. Positivist theory aims to specify relationships between variable concepts in order to explain and predict these relationships and generate hypotheses for further research. In contrast, interpretative theory emphasises understanding what is studied, and sees truth as provisional. It looks for multiple emerging realities (Charmaz 2006).

Constructivist theory also assumes an ever changing world and multiple realities. The constructivist approach starts with individual experience and asks how it is constructed, acknowledging that the interpretation of the responses is in itself a construction.

The post positivist paradigm sees objectivity as paramount. Martens (2008) refers to this as the “view from nowhere” and argues the case for interaction between the researcher and the participants in order to gain a depth of understanding of their experience which is not possible in more objective approaches to research. He also believes that building trust between the researcher and the participant avoids the view of the researcher as an ‘exploiter’ who takes knowledge from participants and then disappears. Morgan (2009) refers to positivism as the dominant research paradigm in the late 1970’s but sees a paradigm shift towards a pragmatic approach to research, which offers new opportunities for addressing methodological challenges in certain types of research and removing the barriers between inductive and deductive approaches.

Charmaz (2006) sees interpretative qualitative research methods as a means of entering the research participants’ world. She confirms the need to attend to what we see, hear and sense during interaction with a research participant in order to learn about their life. These impressions can then be compared with the interactions with other participants to identify the similarities and contrasts. Charmaz believes that this culminates in “an abstract theoretical understanding of the studied experience” (2006: 4).

Reflexivity is an essential part of the pragmatic approach, in order to avoid giving objective status to assumptions and interpretations made by the researcher. These assumptions affect the social process of the study and need to be examined at every stage. Charmaz (2006) sees interaction as interpretative as we appraise what occurs in different situations and use language and culture to create meaning for ourselves.

This interpretative approach is relevant for both participants and practitioners in a research context. Smith (2009) describes reflective practice as an opportunity to return to encounters in clinical practice and explore feelings and behaviour and thus re-evaluate



the experience. This process generates practice based knowledge. The process of reflective practice informing research transposes the usual view of research informing practice. In Smith's view this is an equally valid way for practitioners to develop knowledge and skills.

The philosophy which underpins this research is also pragmatic. Homeopathy is one of many healing interventions. Individuals and society have choices about how to manage health care which must be respected. In both the literature and in practice, there is evidence of homeopathy making a difference to the health and well being of individuals, but this should not lead to an evangelical approach to promoting homeopathy. The pragmatic view constantly questions what is happening and highlights the need to review which aspects of homeopathic practice may have influenced outcomes of treatment. This includes a belief in the self healing capacity of the body, but also awareness that there are times when self care and positive thinking are not cure alls. Conventional medicine is an essential part of the pragmatic view of health care. This is not incompatible with the view that there should be less use of medicines to suppress symptoms and more personal responsibility for health care. An increase in the availability of integrative health care in the NHS, including homeopathy as an option for those who choose it, seems a desirable goal.

The pragmatic view of research and practice does not mean that there is inconsistency in the treatment of individuals and a lack of philosophical basis to practice. The pragmatic view supports a responsive approach to those who have chosen homeopathy as their preferred method of health care. Outcomes for these individuals are often consistent with classical homeopathic theory and philosophy and with evidence from homeopathic literature. Part of the treatment process involves gaining the trust of patients, showing empathy and maintaining high standards of professional conduct. In practice, patients report that they value kindness, listening, non judgemental responses, efficiency and availability to answer questions between appointments. These approaches to patient care are consistent with a pragmatic approach that is responsive and patient centred.

Undertaking research in homeopathy is part of a personal quest to understand what happens in the homeopathic process and to find out if it can be of value to contemporaries as they face health issues associated with later life. Acting as both a researcher and practitioner, challenges the usual concepts of research. This challenge is consistent with the pragmatic approach to research and the epistemological view of reality as characterised by change and open to multiple interpretations.

## 2.3 DESIGN OF RESEARCH STUDY

The aim of this study is to present valid and well substantiated conclusions about the following research questions:

- ❑ Is homeopathy perceived to be effective in improving health and well being and quality of life in the 55+ age group?
- ❑ What are the common themes in the experience of homeopathic treatment described by participants in this study?

In order to do this both qualitative and quantitative research methods were chosen. The central premise of mixed methodology is that the use of both quantitative and qualitative data provides a better understanding of the research issues than either can do alone. Data can be connected or compared to provide a more complete picture than is possible with only one type of data. Mixed methods offset the weaknesses of both types of data collection. For example, qualitative data includes the context and voice of participants but there is a risk of researcher bias or interpretation of data. There is also difficulty in generalising results from qualitative data. On the other hand, quantitative data offers greater objectivity and validity as a result of using procedures based on external standards and past research (Creswell et al 2008).

The most recent research into methodology for evaluating homeopathy as a complex intervention recommends using both quantitative and qualitative methods. The research methods chosen for this study are based on this recommendation, using multiple methods of data collection and analysis (Weatherley-Jones et al 2003, 2005).

There are different types of research design for the use of mixed methodology. These include triangulation, embedded, explanatory and exploratory designs (Creswell and Piano Clark 2008). The triangulation design aims to obtain complementary data from

quantitative and qualitative data. The embedded design has a main source of data and the other data set provides a secondary, supportive role in the study. Unlike triangulation the aim is not to converge data sets but to report them separately. The exploratory and explanatory designs are not concurrent and therefore less suitable for this study, which is based on participant consultations not research interviews.

The use of a concurrent embedded design for this research study, allows for the main data source to be qualitative, based on the individual responses of participants, but also to use quantitative methods to gain a more objective view of their experiences and any changes in their health as a result of the treatment process. In this study an embedded mixed method design allows for the use of quantitative data as secondary supportive evidence and qualitative data as the main source of evidence of the outcomes and process of treatment.

The key concept that has informed the design of this study is the need to ensure that data is considered trustworthy. To ensure that the combined role of practitioner and researcher does not undermine the validity of the research, the study has been designed so that it includes measures which confirm the trustworthiness of the data. The rationale for achieving this trustworthiness is based on transparency, consistency and honest presentation of all aspects of the research.

## **2.4 TRUSTWORTHINESS OF RESEARCH DATA**

Trustworthiness in all aspects of the research process has been achieved by clearly stating the aims of the study and the rationale for the chosen methodology and analysis of data. The literature on research validity, reliability and reflexivity supports the chosen design for this study as most likely to ensure the trustworthiness of data.

### **2.4.1 The aims of the study**

By stating clear aims for the study and linking these with a pragmatic world view and established principles of classical homeopathy, the purpose of the study is confirmed. The aims of the study focus on perceptions of individuals about health and well being and the experience of homeopathic treatment. This highlights the philosophical assumptions that underpin the study, specifically the focus on a pragmatic view of the research study which acknowledges change and unpredictability. This allows for inconsistency in results, different perceptions of outcomes and discrepancies in individual experiences of homeopathic treatment.

### **2.4.2 The chosen methodology**

The use of a mixed methodology, including both quantitative and qualitative data in an embedded design supports the trustworthiness of data collection by offering a range of different methods for gathering data. The embedded design does not combine data to achieve a single outcome, as in triangulation of data, but presents data as primary and secondary. The primary data is the qualitative data which supports the aims of the study by gathering perceptions from individuals about their experience of homeopathic treatment. The quantitative data is gathered as a secondary source, which may confirm or

contradict the qualitative data, but provides a more objective measure of the perceptions of participants in the study about the outcomes of treatment.

### **2.4.3 The practice of homeopathy**

The homeopathic approach used in practice and research in this study is based on known principles and philosophy of classical homeopathy, supported by a thorough literature search and continuing professional development. By following the principles of classical homeopathy, the study was based on a defined system of practice which could be used to evaluate outcomes and could be replicated in future studies. It was important that the size of the study was both manageable for a single practitioner and meaningful for research purposes and was carried out in an agreed timescale. By using a consistent approach in all aspects of practice and research and reviewing practice regularly with supervisors and other professionals to ensure ongoing consistency, the trustworthiness of the research process was confirmed. Consistent and detailed records of all data have been organised and stored efficiently and safely and have been rigorously checked, also ensuring that the research could be replicated based on these documents.

### **2.4.4 Supervision of the research process**

Supervisors and other supportive professionals were also able to check the data collection methods and ensure that the data itself was valid and trustworthy. Self supervision was used to reflect on the process of homeopathic treatment and consider any bias or conflicts that arose in practice. This was recorded in a reflective journal which was also used as part of the data collection process. Throughout the research, meetings with supervisors and other professionals provided opportunities to question and challenge research methods and analysis of data collected.

### **2.4.5 Analysis of data**

The analysis of data is described in detail in later sections of the methodology but the process was designed to ensure the trustworthiness of the published outcomes. Both the process and the data were scrutinised to compare evidence and make connections between different experiences of individuals and the research cohort as a whole. Results were subjected to detailed scrutiny and frequent reviews. The statistical data was analysed in a variety of ways in order to determine its value and also to consider if there was any statistical significance in the outcomes of the study, despite the small number of participants. By honestly accounting for discrepancies in data and analysis, the transparency of the process and the outcomes was confirmed.

The literature on research validity, reliability and reflexivity supports the chosen design for this study as most likely to ensure the trustworthiness of data.

### **2.4.6 Validity of research methods**

Validity can be defined as the accuracy with which researchers draw inductive and deductive conclusions from a study. Creswell and Piano Clark (2008) acknowledge that there are issues of validity in mixed methodology research and suggest specific strategies for addressing these issues. They recommend triangulating different data sources to develop coherent themes in data analysis. The use of detailed description to support findings, peer review of the study, the use of an external auditor, honest and open researcher reflexivity and the presentation of discrepant information are also ways of increasing the validity of the research findings.

Creswell (2009) also refers to ‘inference quality’ which describes the researcher’s ability to draw meaningful and accurate conclusions from the data collected in a study. He believes that there is an overarching validity which comes from the use of different

datasets. Conclusions are also likely to be more meaningful if both the process and the outcome of the data is analysed.

Marshall and Rossman (1995) believe the soundness of research should be based on responses to the following questions and criteria:

- ❑ How credible are the findings of the study?
- ❑ By what criteria can they be judged?
- ❑ How transferable and applicable are the findings to another setting or group of people?
- ❑ Can the study be replicated in the same context and with the same participants?
- ❑ How trustworthy is the research as a reflection of the inquiry itself and not the researcher's biases and prejudices?

They refer to the work of Lincoln and Guba (1985) who put forward alternatives to the usual research terms of internal validity, external validity, reliability and objectivity.

They suggest that for qualitative research alternative constructs could be used:

- ❑ credibility, ensuring that the subject was accurately identified and described
- ❑ transferability, in which judgements are made about the relevancy of the study to further study (triangulation is regarded as an additional means of increasing the transferability of qualitative findings)
- ❑ dependability, in which the researcher attempts to account for changing conditions in the study, directly contrasting with the positivist notion of an unchanging world
- ❑ confirmability, which seeks to affirm objectivity by asking whether the findings of a study could be confirmed by examination of the data by others

In summary, the researcher focuses on recording the complexity of the research situation as it occurs and recording and storing all data in a well organised and retrievable form.



Cohen et al (2000) describe concepts of validity and reliability as multi-faceted and caution against believing that threats to validity and reliability can be erased completely, particularly in qualitative research. The definition of validity as a demonstration that particular instruments of research measure what they purport to measure is developed to include aspects which are more relevant to qualitative research. These include honesty, scope of data, the extent of triangulation and the objectivity of the researcher. They stress that subjectivity of respondents in qualitative research creates an inbuilt bias which should be acknowledged. They suggest that the following types of validity are most important in qualitative research:

- ❑ descriptive validity providing factual accuracy in recording accounts of what happened and what was said
- ❑ interpretative validity which is faithful to the meaning and intention of the research participants
- ❑ theoretical validity which provides explanations for research phenomena
- ❑ generalisability of findings, making them useful in analysing similar situations
- ❑ evaluative validity ensuring that an evaluative framework is used to challenge judgements made about research data

Internal validity ensures that explanations provided by a piece of research can be sustained by data collected (Cohen et al 2000). This can be achieved in a variety of ways but particularly by creating confidence in the data, through efficient methods of data collection and recording and rigorous checking of data. Triangulation is also regarded as an important method of achieving greater internal validity.

External validity is defined as the degree to which results can be generalised to the wider population. In qualitative research this can be more difficult as the aim is often to capture the complexity of human experience which cannot easily be reduced to transferable conclusions. Cohen et al (2000) suggest that providing detailed descriptions of findings and in depth analysis allows future researchers to assess the applicability and transferability of particular research to future studies, and therefore provides greater external validity.

Content validity refers to the ability of the research methods to comprehensively cover the topic under investigation. The elements of the research need to be a fair representation of the wider issue. This may impact on issues such as the choice of the study population for a research study.

Construct validity refers to the view taken by the researcher of the topic and how well this relates to the general acceptance of the construct under investigation. In the case of homeopathy, the view of classical homeopathy is well defined but newer constructs such as complex homeopathy are open to different interpretations. Establishing construct validity means ensuring that the researcher's construct agrees with other constructs of the same issue. This can be done through an extensive literature search and looking for counter examples offering refuting evidence and acknowledging any discrepancies in the interpretation of the construct.

Cohen et al (2000) refer to minimising threats to validity by choosing an appropriate timescale and number of participants, selecting appropriate methodology for the research question, and ensuring internal, external, content, concurrent and construct validity, along with reliability in terms of stability and consistency. During the data gathering process, invalidity can be tackled by reducing the Hawthorne effect (respondents behaving differently under scrutiny) and minimising participant reactivity, avoiding drop outs, ensuring standardised procedures for gathering data and reviewing researcher behaviour to ensure consistency, for example, in attitude, dress, comments. At the data analysis stage, validity can be preserved by avoiding subjective interpretation of data, reducing the halo effect and selective use of data, and correctly analysing statistical data.

In summary, validity is about transparency in the collection and storage of data, consistency in all aspects of the conduct of a research study, openness to different interpretations when analysing data and thorough and reflexive appraisal of all aspects of the research design.

### **2.4.7 Reliability of research methods**

Reliability refers to the consistency and replicability of the research methods used, ensuring that similar results would be achieved if the research was repeated with a similar group of respondents in a similar context.

It is more difficult to ensure reliability in qualitative research but this can be addressed by ensuring the fit between what the researcher records as data and what occurs in similar situations outside of the research context. By recording a holistic view and therefore multiple perceptions of the same experience, the researcher attempts to provide data which dependably portrays the situation being studied. By using reflective journals, peer review and independent audits, results can be confirmed as reliable, even if they are open to different interpretations. Cohen et al (2000) summarise the nature of reliability in qualitative research by referring to fidelity to real life, authenticity, detail and depth of response.

Cohen et al (2000) also state that many researchers subscribe to the use of mixed methodology, but in practice few researchers make use of two or more methods of data collection. They value the attempt in mixed methodology to explain more fully the richness and complexity of human behaviour by studying it from more than one standpoint. Exclusive use of one research method may bias the researcher's view or distort the outcome, but using different methods that yield similar results, promotes confidence in the findings.

Stability can be defined as the reliability of research measures over time. This can be achieved by selecting an appropriate timescale between testing and retesting respondents. Stability over a similar sample can be achieved by matching participant characteristics, so that responses are comparable, based on age for example. Further reliability can be achieved by using equivalent documentation for all participants.

### 2.4.8 Reflexivity

Reflexivity is part of the process of ensuring validity and reliability of any study, particularly in a study involving qualitative data and the dual role of practitioner and researcher. Reflexivity may be defined as an awareness of the researcher's involvement in the process of gathering data and an acknowledgement of the difficulty of remaining outside that process.

Willig (2001) identifies two types of reflexivity, personal reflexivity and epistemological reflexivity. Personal reflexivity refers to an acknowledgement of the way in which the researcher's values, personality and life experiences may shape their involvement in the research process. Assumptions made by the researcher can affect the social process of the study and need to be examined at every stage. Epistemological reflexivity questions the research design and process of gathering data, encouraging reflection on assumptions made about the research and the implications of any such assumptions for the validity of the research. Charmaz (2006) sees reflexivity as an essential part of the pragmatic approach.

Personal reflexivity is addressed in this study through the use of a reflective journal and the process of questioning and discussing research methods with supervisors and other professionals. The ongoing process of questioning assumptions is part of the training and practice of classical homeopaths. It is embedded in the principles and philosophy of homeopathy. Samuel Hahnemann, the founder of homeopathy, requires practitioners to be "unprejudiced observers" (1810: aphorism 6) as they listen to the account of a patient's illness and history. He warns homeopaths to avoid making assumptions that one case is like another, or that the same remedy that was successful for a disease with one patient will work with someone else who appears to have the same complaint. This practice of questioning all assumptions is so firmly embedded in the homeopathic approach to treating patients that it is possible to assume that it happens automatically, and this is the key assumption that any homeopath must challenge.

Epistemological reflexivity is also addressed through the use of a reflective journal and the process of questioning research design and methods. Willig (2001) poses particularly relevant questions for this research:

- ❑ How has the research question defined and limited what can be revealed by the study?
- ❑ How has the design of the study and the method of analysis defined and limited the data and the findings?
- ❑ Could the research question have been investigated differently and would this have given rise to a different understanding of the issues?

These questions are addressed further in *Chapter 4: Discussion*, but some commentary is included here about the consideration of these issues in the early stages of research planning.

The research questions for this study refer to perceived outcomes of treatment and participant evidence of themes in the process of homeopathic treatment. Although quantitative measures are used to assess the outcomes of treatment these are still based on individual perceptions of health and well being and any changes that take place as a result of treatment. The possibility of generalising data to a wider population is therefore limited by the research question and the size of the study cohort. An element of subjectivity is also possible in selecting and analysing themes revealed in the data provided by participants. Is a single comment that is different from all the others as valid as a comment that is made by several participants and is therefore selected as a theme? Reflection on all commentary from participants is essential to ensure that important contributions are not undervalued.

Willig (2001) also asks researchers to consider if the design of the study and the method of analysis ‘constructed’ the data and the findings. In this study the purpose of the design was to reveal as many different perspectives as possible on the research question. This can make analysis of the data more difficult as the quantity and diversity of data in this

kind of study can become unmanageable. It requires a systematic approach to organising and analysing data and consistent methods of carrying out these tasks. In this study, these approaches have been constantly monitored and reviewed to ensure that the openness required to review the data is maintained throughout.

By limiting the scope of the research questions and research methods used, more specific insights into homeopathic treatment may have been gained. Homeopathy is a complex topic and the 55+ age group encompasses a large section of the population. By narrowing the question and limiting the study to a more specific age group it might have been possible to gain a clearer focus on the issue of the effectiveness of homeopathy in improving health and well being. This would also have had disadvantages by reducing the openness of the topic, particularly as it is difficult to define the 55+ age group and their health problems are complex. Important insights may have been lost. It would have been possible to include a control group who did not take the homeopathic remedy, but the size of the study population made this less feasible. This may also have focused attention on the action of the homeopathic remedy which was not the primary focus for the chosen research questions.

The most common approach in research on homeopathy is to measure the effectiveness of a remedy, or the effectiveness of homeopathy on specific symptoms. The aim of this study was to go beyond this familiar approach and consider homeopathy as a complex intervention which might be useful in an age group where health problems are more common and more complex.

## 2.5 RESEARCH METHODS

The chosen research methods for this study involve analysis of the following data:

- ❑ semi-structured interviews
- ❑ participant case notes
- ❑ practitioner reflections
- ❑ MYMOP questionnaires
- ❑ SF-36 Health Survey

### 2.5.1 Qualitative methods

The qualitative methods chosen for this study are the analysis of case notes taken during homeopathic consultations and semi-structured interviews with participants at the end of the treatment process. This analysis will focus on common themes revealed by participants about homeopathy as a complex intervention. This evidence will be matched with the practitioner's reflective commentary as a shared participant in the experience.

Basic qualitative analysis involves analysis of themes and perspectives which are then reported under relevant headings. Creswell (2009: 4) refers to “qualitative theme analysis of text data” and identifies steps for analysing data in this way: firstly by reviewing raw data, then organising the data, re-reading data to identify themes and then interpreting the meaning of emerging themes. This approach is widely used in research in the social sciences to consider the experience of participants and not just the outcomes of the study. Participants are asked open, non-directive questions and their responses are structured into themes and clusters and finally into a summary table (Willig 2001).

Qualitative research methods such as grounded theory and interpretative phenomenological approach (IPA) were considered less suitable for this study. In grounded theory categories of meaning emerge from data collected by grouping experiences with common

characteristics such as emotions. In this kind of categorisation there is a risk of losing some of the complexity of the individual experiences. For example, homeopathic patients may refer to the emotion of anger but experience it in very different ways. IPA is based on the belief that all description is a form of interpretation and understanding is based on at least some assumptions. The process of analysis of data used in IPA again uses a cluster approach, grouping experiences under thematic headings which are an interpretation by the researcher of the participants' use of language and meaning. For this study, it was important to retain the words of the participants as part of the process of presenting individual perceptions of treatment and avoiding researcher bias. Additionally, data collected during homeopathic consultations is used to select an appropriate homeopathic remedy, not specifically for research purposes as in research interviews. For these reasons, basic thematic analysis of textual data provided in the case notes and interviews was chosen as the preferred qualitative research method.

Qualitative reliability requires that the researcher's approach is consistent throughout the study. This can be seen in the use of consistent methods for treating participants and documentation used to record this. In this study, transcripts were checked by supervisors and all data stored electronically and in paper copies to be available to confirm details of the study. (A CD-rom is attached to this document containing transcripts of all interviews and computer analysis of quantitative data.)

The issue of generalisability and external validity has been seen as less achievable for qualitative data than for quantitative research. External validity is based on research results that can be replicated. Qualitative research is usually based on a researcher's unique perspectives on a particular situation and this is less easy to replicate. However, the increased use of qualitative research has led to a greater interest in generalising data collected in this way. Schofield (2007) describes the current approach as a matter of 'fit' between the situation studied and others to which conclusions might be applied. Qualitative findings reflect individual experiences recorded in the research findings. Creswell (2009) believes that despite this the results are generalisable by making connections with broader existing theories which are relevant to the topic.



Marshall (1995) lists criteria for assessing the trustworthiness of qualitative research:

- ❑ an audibility trail or running record of procedures
- ❑ researcher self analysis for bias
- ❑ avoiding value judgements in data analysis
- ❑ presentation of data in accessible form
- ❑ presentation of evidence which includes acknowledgement of ambiguity
- ❑ maintaining ethical standards
- ❑ efficient data collection systems
- ❑ use of historical perspectives to show how situations have evolved

As a result of constantly reviewing the planned approach to reliability and validity in this study, it is hoped that these criteria have been achieved.

### **2.5.1.1 Semi-structured interviews**

The aims of the research study were to determine whether homeopathy is effective in improving perceived health and well being in the 55+ age group and to explore common themes in the homeopathic treatment process. Interview questions were created to reflect the requirements of the research questions and the literature on CAM research, specifically information about possible influences on outcomes of treatment other than the therapy being used. Questions were revised and reviewed in consultation with supervisors and a homeopathic adviser. The interview questions are described and analysed below and the full text of the interview questions is included in Appendix 4.

**Interview question 1**, “What was your view of homeopathy before starting treatment?” was designed to find out what information and beliefs participants had about homeopathy before starting treatment in order to assess the impact of prior knowledge and beliefs on treatment. Participants were provided with information about homeopathy in writing (see Appendix 6) and verbally at the beginning of their first consultation (see Appendix 8).

**Interview question 2**, “How would you describe your experience of homeopathy to someone who knew nothing about it?” was designed to assess whether participants had an understanding of the philosophy of homeopathy and could describe this to others.

**Questions 3, 4 and 5** asked participants to assess the impact of different aspects of the homeopathic process.

“Tell me about your experience of the homeopathic consultations.”

“Tell me about your experience of the effects of taking the homeopathic remedies.”

“Tell me about your experience of discussing self care in the consultations and the effect on your behaviour between consultations.”

Each of these aspects of treatment has been credited with improving health and it was hoped that participants would be able to evaluate the separate aspects of the treatment process.

**Question 11** followed on from the questions about specific aspects of the treatment process by asking participants to state what they believed had made the most difference to their health.

“Which of the following made the most difference to your health: the remedy, interaction with the homeopath, self care or any other factor? Give some reasons for your answer if you can.”

**Question 6** asked participants directly if they thought their beliefs had an effect on their health.

“Do you think your beliefs about homeopathy, or your beliefs about health, or the placebo effect, made any difference to the outcome of the treatment? Give some reasons for your answer if you can.”

Similarly in **questions 7 and 8** participants were asked to evaluate the effect of the therapeutic relationship on their health, and the effect of contact with the homeopath between appointments.

“Do you think the therapeutic relationship with the homeopath made any difference to the outcome of the treatment? Give some reasons for your answer if you can.”

“Do you think contact with the homeopath between appointments, by e-mail, phone or letter made any difference to the outcome of the treatment? Give some reasons for your answer if you can.”

**In questions 9 and 10** participants were also asked to assess the accuracy of their account of their health and any impact that the homeopath had on their reporting of changes in their health.

“Do you believe that you accurately described your symptoms and changes that you experienced during treatment? Give some reasons for your answer if you can.”

“Were your responses in the homeopathic consultation affected by your view of the homeopath or her questions or comments? Give some reasons for your answer if you can.”

**Questions 12 and 13** asked about the effect of payment on their view of treatment and the effect of seeing the homeopath in a home office.

“This is a research project and consultations were free of charge. Did this make any difference to your view of the treatment process? Give some reasons for your answer if you can.”

“The consultations were carried out in a home office. Did this make any difference to your view of the treatment process? Give some reasons for your answer if you can.”

**Questions 14 and 15** offered an opportunity for participants to provide additional commentary about their experience of homeopathic treatment.

“Is there anything that you would change about your experience of homeopathic treatment?”

“Any other comments”

Participants were interviewed at the end of the final consultation. After the consultation participants were offered a break and refreshment and when they were ready the interview commenced. Participants had received the interview questions in advance of the interview and some had prepared written answers which they brought with them, but others had only briefly considered the questions in advance. All questioning and responses were recorded on a digital tape recorder. Participants were introduced to the process and the recorder was placed on the arm of their seat. Most participants seemed to forget that they were being recorded and only commented on the recorder when it was switched off at the end. Each question was read out by the homeopath/researcher and responses were generally listened to without comment, but with thanks and non verbal appreciation. The only reason for the interviewer to speak was when participants asked for clarification or seemed to have misunderstood what was said.

After each interview, the recording was transcribed verbatim and line numbers added to the text. Any use of quotations from interview transcripts in the presentation of results is accompanied by the line number in order to facilitate an audit trail of the origin of selected quotes. Analysis of the interviews took place when all interviews were completed. All participants were interviewed once at the end of the homeopathic treatment and therefore a total of 20 interviews were transcribed.

Smith and Osborn (2008) refer to thematic analysis of participants’ language as a way of exploring how participants make sense of their personal and social world. This focuses on an individual’s perception of events or experiences and does not aim to provide factual or objective statements about the experience. This also involves the researcher as an active participant in the process. It assumes a connection between what individuals say and their

thoughts and emotions. Smith and Osborn (2008) confirm that there is no single, definitive way to carry out analysis of data collected from participants but they suggest that it should involve detailed analysis of transcripts of semi-structured interviews. Transcripts are then interpreted to identify themes through analysing use of language and implied meaning or underlying emotion. Clusters of themes and subordinate themes are then presented in the form of a table.

This approach was used in analysing the data collected from participant interviews. Line by line analysis of the responses to each question was carried out, highlighting key themes. These were then listed and grouped in a table for each question, according to similarities or apparently significant commentary. (See Appendix 9 for an example of analysis of interview question 1) The aim of this approach was to identify any experiences that were common to participants and highlight any variations in individual responses to the questions. Some themes were predetermined by the subject of the research and the use of common questions in participant interviews. Other themes emerged as a result of analysing participant responses and comparing their experiences.

The selection of themes was based on the following criteria:

- ❑ connections made by participants with the research questions, specifically commentary on the effectiveness of homeopathy and the experience of homeopathic treatment
- ❑ responses to predetermined interview questions which had a thematic quality
- ❑ comparisons of participant responses revealing common experiences or differences in views expressed about the experience of homeopathic treatment

Sub-themes were identified for each of the main themes, based on similar criteria but also focusing more specifically on participant responses that were similar or very individual. Themes and sub-themes were reviewed frequently as data was re-analysed and evidence for selecting these themes and sub-themes became clearer. Data that was excluded from the selection was either confidential to the participant or unrelated to the research question. Individual participants also speculated on the nature of the experience of

homeopathic treatment, particularly when asked about their views on placebo and the importance of the therapeutic relationship. These speculations were used in the thematic analysis and presented as individual viewpoints.

Reid, Flowers and Larkin (2005) believe that the interviewees are the experts on their experience. Analysis of their use of language should avoid making assumptions or testing a hypothesis but aim to capture the meaning that participants ascribe to their experiences. Analysis of data in this study focuses on what is distinct for the individual but also what is common across the group of participants. This view of the interviewees' role influenced all considerations of their contributions.

Validity in the use of interviews for research purposes is cited as a persistent problem by Cohen et al (2000). They refer to a tendency in interviews for respondents to overstate or understate the true value of an attribute. Validity can be established by comparing data collected at interviews with another form of data collection. Bias can also be limited by acknowledging the influence of the interviewer on the respondent and avoiding leading or confusing questions. Reliability is greater in interviews if they are highly structured, using the same format, wording and sequence of questions. Accurate transcribing of respondents' answers also increases the reliability of the interview. In the presentation of results for this study, extensive use has been made of direct quotations from the participants in order to be faithful to their commentary and to support the trustworthiness of the research.

Trustworthiness of interview data was addressed in this study by attempting to be consistent in the presentation of interview questions and in valuing all responses to questions. Questions were directly linked to participants' experience of homeopathic treatment and expressed as clearly as possible with no attempt to elicit a particular type of response. The transcription of interviews was carried out soon after the interviews took place and reviewed several times to ensure accuracy. Participant interview transcripts and analysis were reviewed by Queen Margaret University (QMU) supervisors who read 25%

of transcripts and all of the analysis. (Anonymised versions of interview transcripts are provided in a CD-rom attached to this document)

### **2.5.1.2 Case notes of participants**

Data from the case notes taken at the homeopathic consultation is presented as original descriptive data. It provides an account of the participants' experience based on generalised questions. The participants' responses in the semi-structured interview at the end of the treatment process were transcribed verbatim from a digital recording. Giorgi and Giorgi (2008) make a distinction, which is relevant to this study, between transcribed interviews and original descriptive data, such as that taken from case notes.

Murray (2008:113) defines narrative as “an organised interpretation of a sequence of events” and refers to the tendency to use narrative to restore order when our lives are disrupted by problems or challenges, or as a way of shaping events into an interconnected sequence with a beginning and an end. He refers to the use of narrative in exploring the experience of ageing. The telling of the story also involves the listener and Murray refers to the “joint production” as the listener encourages the telling of the narrative.

In the homeopathic consultation, the patient is encouraged to tell their story in their own way. The homeopath may question aspects of the story to elicit more detail or clarify the nature of an experience but does not contribute to the narrative. The structure of the homeopathic consultation is also defined by the way the patient talks about health issues. The patient is invited to explain what was happening at the time their illness began and something about their life and health history, but many participants provide this information without being prompted. They also make connections for themselves between events and their health, sometimes only making that connection for the first time as they hear themselves tell their story. Although the homeopathic consultation fits into the narrative research category, it is a unique approach to gathering information which has a specific focus, to enable the homeopath to select a remedy for the patient. It also

allows the patient to tell their story in the way that suits their needs. These needs may include expressing strong emotions, apportioning blame, limiting what they say, talking about things that are not personal to avoid their story, or simply talking until they have nothing else to say.

The case notes were typed up as the participants spoke. This was not a verbatim account, as this would have limited the sense the participant had of being listened to and cared for in the consultation. The review of the case notes was first of all part of the process of selecting a remedy which matched the symptoms and personality of the participant. This was not part of the analysis of the case notes for research but inevitably increased the understanding and awareness of what participants said.

The typed account of the consultation was detailed and as part of the homeopathic process included the participant's exact use of language whenever possible. This was particularly relevant when recording how participants experienced their symptoms and the emotions that they felt. It is also part of the process of reflexivity on the part of the homeopath that assumptions about participants' feelings are not made based on the homeopath's own experience or common human experiences. If the participant's use of language is altered in any way it can result in an interpretation of what was meant based on the homeopath's assumptions about meaning.

Some accounts of participant experiences could be regarded as extremely sad, and in some cases quite harrowing to listen to, but individual participants did not always express these emotions. By recording the use of the exact words used by the participant it was possible to select the most appropriate remedy for the emotional state of the participant. An example of this would be the use of the word 'alone'. For one participant this was clarified to mean a feeling of abandonment and this is a key symptom in the remedy picture of Pulsatilla. For another participant this was described as a feeling of being 'disconnected' and this led to the remedy Sepia. This type of analysis is part of the homeopathic process of case analysis and is fundamental to the choice of the most appropriate remedy.



The use of case notes for research purposes was inevitably limited by the need to preserve confidentiality. For this reason, direct quotes were not included in the presentation of results. Each participant's case notes for each of the four appointments was reviewed and information was extracted and put into tables covering specific aspects of the homeopathic experience. These aspects were chosen to reflect the information that is important in homeopathic case taking and the information that was relevant in terms of the 55+ age group and the type of health problems reported.

This included:

- ❑ information about participants, such as age, employment, marital status (some of this information was provided in an initial consultation form and some during the consultations but participants were not obliged to provide this information)
- ❑ dates of appointments (see Appendix 10)
- ❑ remedies prescribed (see Appendix 11)
- ❑ physical symptoms described by participants
- ❑ emotional symptoms described by participants
- ❑ exciting and maintaining causes of health problems
- ❑ life traumas described by participants
- ❑ traumas experienced by participants during the study
- ❑ unexpected outcomes of treatment described by participants

To gain an overview of the evidence from case notes, they were reviewed again and the content summarised under the following headings:

- ❑ presenting symptoms and history
- ❑ common themes and participant experiences (see Appendix 12)

Analysis of language used in the case notes was initially for the purpose of selecting a remedy. Key phrases used by participants to describe their experience of illness or personality traits or strength of feeling were highlighted and used in the homeopathic analysis of the case. Highlighted phrases were then extracted and grouped into relevant categories for repertorisation of the case. These phrases are then used to find the most appropriate term for use in the computer analysis of the case using CARA software (see

example in Appendix 2). Although the computer software uses the language of repertorisation, which comes from the original proving, it is not always the same as modern language. The phrase ‘fastidious’, for example, in the old texts is frequently used for people who describe themselves in modern language as compulsively tidy. People who worry about detail are described in the repertory language as ‘conscientious about trifles’. After these symptoms and characteristics have been entered into the computer programme, the software generates a list of remedies that have been categorised in past provings as relevant for a particular symptom. These remedies are scored for symptom severity. The homeopath then refers to the *Materia Medica*, which gives the detailed remedy picture, to select the most suitable remedy for the individual.

The analysis of the case notes for research purposes was approached in a similar way to the analysis of the participants’ responses to interview questions. A line by line analysis was carried out and phrases or sentences that seemed meaningful in terms of the research questions were highlighted. These were then summarised in tables which identified the participants and the comments they made, revealing differences between participants and identification of common experiences. An example of this is included in Appendix 13. These comments were also reviewed to take account of the context of individual stories. For example an individual who was recently bereaved and was experiencing sadness was not placed in the same category as someone who was suffering from ongoing depressive symptoms.

The process of analysing case notes was a painstaking task that involved reading and re-reading case notes for 80 appointments and selecting thematic data to support the research process. This provided a very rich source of data about participant experiences and homeopathy, but the confidentiality of the case notes and the sensitivity of the content made it difficult to present relevant data. The limited data that can be presented does not represent the rigour of the process which is summarised in the following table.

**Table 2: Summary of tasks and processes involved in analysis of participant case notes**

<b>Stage</b>	<b>Task</b>	<b>Process</b>
1	Homeopathic analysis of case notes leading to selection of remedy	Identifying phrases in the consultation notes that are significant in terms of: - homeopathic theory and philosophy - the importance to the individual - the strength of emotion expressed Transferring selected phrases into language for repertorisation
2	Analysis of case notes for research purposes	Line by line analysis of language used and selection of key phrases which relate to the research questions, or appear significant to the individual, or are repeated by more than one person
3	Review of analysis of case notes	Review of all selected phrases to evaluate their importance in terms of the research, comparing choices made for homeopathic case analysis and the context of commentary from participants
4	Grouping selected phrases under appropriate headings	Identifying common themes in the selected phrases and placing these in a table with the participant numbers in the left hand column and themes across the top of the table
5	Summarising and grouping evidence collected from case notes	Reviewing all tables and selected phrases to find what is common for individuals and for several participants and summarising this information under generic headings

### **2.5.1.3 Practitioner reflections**

Qualitative methods focus on the perspective of individual participants, giving emphasis to the meanings participants attach to their experiences. The researcher may further interpret the views of the participants and there is a need to acknowledge this and find ways of limiting distortions that occur as a result of any researcher interpretations that are based on their own values and experiences.

The researcher's perspective in this study was captured in a reflective journal and recorded after each consultation with participants. Additional reflections and observations were recorded in the consultation notes. These included changes in the participants' behaviour or appearance and issues which arose for the homeopath/researcher as the participant was speaking.

The reflective journal was not edited at any time or added to after the practical research phase of the study was complete. The journal was reviewed periodically but not analysed until the study was complete. It was completed after each consultation or contact with participants in the study and therefore was closely linked to the case notes. It was analysed thematically in a similar way to the interview transcripts and the participant case notes.

The purpose of the reflective journal was to highlight feelings and assumptions experienced by the homeopath/researcher in order to promote greater reflexivity and identify questions which needed to be considered. The reflective process was supported by the use of supervision. This is a key part of continuing professional development for CAM therapists and a valuable opportunity to explore practical, ethical and emotional issues which arise during consultations with patients.

Owen (2008) refers to the role of the homeopath in exploring interconnected causes and consequences of suppression of emotion in their patients' lives. He believes that

supervision helps to make the patients' stories more whole for the homeopath. He highlights the importance of this when difficulties arise in a case and makes reference to psychotherapy and the theories of projection of the patient's feelings onto the homeopath. He also refers to transference which involves the patient redirecting feelings about someone else to the homeopath and counter-transference when the homeopath's feelings are re-directed to the patient. He describes the homeopath as part of the healing environment and sees the need to monitor the relationship with patients through a reflective process, assisted by supervision.

There are three key reasons for homeopaths to make use of supervision:

- ❑ to avoid becoming overwhelmed by unexpressed feelings about the patient encounter and patient experiences, which may become suppressed and lead to health problems for the homeopath
- ❑ to explore difficult cases and gain greater understanding of the key symptoms by reviewing and discussing the case with a supervisor
- ❑ to explore personal feelings which arise as a result of patient encounters or experiences in the homeopath's life which have an impact on the therapeutic relationship and the ability to be an unprejudiced observer

Owen (2008) describes self-supervision through the reflective process and highlights ways of developing the ability to learn from difficulties. The use of supervision and a reflective journal are important for CAM practitioners and have been used conscientiously throughout this study. The purpose was always to review assumptions and promote openness to different perspectives of participant experiences and behaviour. Additionally it was important to review practitioner approaches and monitor consistent practice and behaviour. This was particularly relevant as interaction with individual participants included their attempts to control and divert the process as well as different behaviours and stories that could prompt unexpected responses in the practitioner. This was not entirely avoidable but reflective practice during consultations and afterwards was an important check on these factors.

## 2.5.2 Quantitative methods

The use of quantitative methods for measuring quality of life and improvement in health is supported by the literature on research methodology. Garratt (2002) asserts that clinical trials should include the patient's perspective on the outcome of the intervention, specifically assessing health related quality of life. He describes two types of patient reported outcome measures, those that are specific to a disease or population and those that are generic and can be applied across populations (Garratt 2009). He defines SF-36 as a generic measure and the most widely used patient reported outcome measure, tested for validity and reliability in hundreds of published studies. He recommends it for studies which aim to measure changes in health and quality of life.

Contopoulos-Ioannidis et al (2009) also note that quality of life and health survey assessments such as SF-36 provide a different view of patient outcomes, focusing on well being and ability to carry out daily tasks rather than relief of symptoms. For this reason, they believe that such questionnaires should be more routinely used to improve clinical decision making by taking account of quality of life issues, rather than focusing only on primary efficacy outcomes of research trials.

The quantitative methods chosen to measure health and well being before and after homeopathic treatment are the questionnaires MYMOP (Paterson 2006) and SF-36 (Quality Metric 2006).

The use of questionnaires was chosen as a means of answering the first research question:

Is homeopathy perceived to be effective in improving health and well being and quality of life in the 55+ age group?

The SF-36 questionnaire (short version 2) is a well validated tool for measuring quality of life and can be used to generate descriptive statistics on the outcome of homeopathic treatment. MYMOP (version 2) is used more frequently in measuring the impact of health

interventions that are complementary or alternative. It is based on health issues identified by participants and their measure of any changes that have taken place in these identified symptoms over time.

These questionnaires were used to provide information to support or challenge the information gathered by qualitative means. The use of an embedded design provides the opportunity to collect data which reveals different perspectives. The questionnaires are not entirely objective as participants are required to score their perception of health issues and these individual perceptions may be based on different values and perceptions of health and well being. The questionnaires do, however, provide an opportunity for participants to provide a more objective judgment of their experience of homeopathic treatment than may be possible in an interview with the researcher who is also the homeopath who has treated them. SF-36 also offers a scoring system that generalizes results for different categories of health and well being and this is an opportunity to carry out limited statistical analysis of outcomes of treatment.

### **2.5.2.1 Measure Your Own Medical Outcomes Profile (MYMOP)**

The MYMOP questionnaire (see Appendix 14) is a patient generated research instrument in which the patient decides what to measure rather than the researcher. This method has been used effectively in GP research (Paterson 1996) and is being used in a major long term study conducted by the Society of Homeopaths (2006). The Society of Homeopaths' recognition of the value of MYMOP in homeopathic research supports its inclusion in this study and provides a consistent approach in homeopathic research. The MYMOP questionnaire requires patients to identify two health issues and one issue that affects their quality of life. The intensity of these problems is measured on a seven point scale and any improvement is scored over time.

This is a valid data collection method for this study because it focuses on aspects of illness that the participants feel are important and outcomes which are valued by participants. The validity of this method has been asserted by Paterson (1996) in a comparison with SF-36 as a means of measuring patient outcomes, and Paterson et al (2000) in a qualitative study of MYMOP. This method has also been used in major studies of homeopathy carried out by the Bristol Homeopathic Hospital (Spence et al 2005) involving 7000 participants and the Society of Homeopaths study (2006). All assert that MYMOP consistently provides clear evidence of outcomes of treatment based on symptoms identified by participants.

Paterson identifies the following advantages of MYMOP:

- ❑ it is responsive while remaining brief
- ❑ it helps the practitioner to be more patient centred
- ❑ it focuses on aspects of illness that the patient feels are important
- ❑ patients are able to assess their own progress using a scoring system and measure changes over time

There are limitations to any subjective measure based on patient perceptions of health and well being, such as MYMOP. Responses cannot be standardised and therefore comparisons across the study cohort have less validity. As individuals select different symptoms and quality of life issues, comparison with other participants in the study cohort is also limited. Participants may also select symptoms that are unlikely to be resolved or symptoms that are self limiting and therefore the efficacy of treatment is harder to measure.

Any measure of health and well being that focuses on individual symptoms is unlikely to be holistic in its approach and is therefore a more limited measure of a holistic therapy such as homeopathy. Jenkins (1996) is critical of MYMOP because it is symptom based. He notes that symptoms which patients present to their general practitioner are often not the main reason for their attendance. He also believes that improvement in symptoms is not the same as improvement in well being. Few studies, other than those involving the



originator of MYMOP (Paterson 2006) and her colleagues, offer evidence of the value of MYMOP as a research tool. It has been used in very large studies of homeopathy and other CAM studies, perhaps in the absence of any other suitable research measure of patient centred outcomes.

### **2.5.2.2 SF-36 Health Survey**

The SF-36 Health Survey (see Appendix 15) is a multi-purpose health survey for adults aged 18 and over. It is a generic measure of health status designed to show changes in health and well being using a rating scale. This measure consists of 36 questions designed to provide information about participants' current physical and emotional health including the ability to participate in work and daily activities. The questions are designed to be easy to understand and relevant to most people's lives. It was originally developed in the USA but is now one of the most commonly used measures of quality of life. SF-36 is described as the most widely used tool for measuring patient reported outcomes, translated into 120 languages and used in 12,000 studies published in the last 20 years covering different health issues and populations (QM Inc 2009).

The questionnaire is designed to be self administered. Scores for SF-36 are calibrated so that 50 is the average score or norm. This norm based score allows comparisons with other surveys and studies. Scores for SF-36 range from 0 to 100, with the higher scores indicating better health.

Ware (1993) found SF-36 to be particularly useful where no standard measures were available for evaluating health, particularly where functioning and well being may vary, even among patients with the same condition. He notes that self reporting systems of recording health outcomes can lack precision but believes this is offset by the short form of SF-36 which places less of a burden on respondents when completing the form.

A large study was carried out by McHorney et al (1994) to test the validity and reliability of SF-36 as a quality of life measure. Their findings support the use of SF-36 with diverse populations for standardised health status measurement. Other researchers have also supported the use of SF-36, including Jenkinson et al (1993) who regarded SF-36 as a potentially valuable tool in medical research. Kiebzak et al (2002) also describe SF-36 as an effective way to document changes in health related quality of life variables in research participants.

The SF-36 questionnaire, even in the short form is complex and this raises issues about its suitability for use with older participants and those whose illness makes concentration difficult. Lyons et al (1994) conducted a study on the use of SF-36 to test out the belief that it was not a suitable measure of health outcomes in elderly people. They found an extremely low rate of missing data and high construct validity in terms of distinguishing between differing health status in participants. They recommend the use of SF-36 in an interview setting as a valid measure of health outcomes in older people.

Hayes et al (1995) also tested the use of SF-36 with people aged 65 and over and found evidence of its sensitivity and validity, particularly when used in an interview setting. Some questions were regarded as not applicable for older respondents. A limitation of the short version SF-36 in their view is that it does not include sleep problems.

Ronan et al (1993) also regarded SF-36 as an appropriate questionnaire for use with an elderly population in an interview setting, noting specifically the validity of SF-36 in distinguishing between those participants with and without evidence of poor health.

The suitability of SF-36 for evaluating well being and quality of life studies involving older people with a range of health issues seems to be confirmed by the literature.

## **2.5.3 Recruitment of participants**

### **2.5.3.1 Inclusion and exclusion criteria for the study**

The criteria for inclusion in the study were that participants were:

- ☐ aged 55 or over
- ☐ able to identify health problems that affected their quality of life
- ☐ willing to attend four appointments with the homeopath/researcher over a six month period and discuss their health and health related issues
- ☐ willing to complete questionnaires and give verbal feedback about their experience of homeopathic treatment

Potential participants with multiple health problems or those taking conventional medication were not excluded from the study, but individuals were not able to take part:

- ☐ if they had had major surgery, chemotherapy or radiotherapy or other significant medical treatment in the previous year
- ☐ if they developed a major illness during the study
- ☐ if they were friends, family, former or current patients of the homeopath/researcher

The population size for the study was set at 20 participants, recruited over a period of approximately a year. Participants were not selected on the basis of gender or age within the 55+ category or from a specific geographical location. Advice was sort from a statistician to decide on the number of participants to be recruited. The number chosen for the study was based on the maximum number that one practitioner could reasonably treat in a limited period of time and the minimum number that would produce meaningful data. 20 participants were recruited for the study and all attended all appointments,

completed all research documents and questionnaires, and took part in the research interview at the end of the treatment process.

### **2.5.3.2 Ethical approval**

Stone (2005) refers to the unique ethical issues raised by complementary and alternative medicine. She specifically refers to the duty to tell the truth, to act honestly and fairly, to respect the wishes of others as individuals with rights, and a duty not to harm people. Her view is that ethics permeate every aspect of the health care encounter and that healing relationships are based on trust. These beliefs are very much part of the philosophy that underpins the conduct of this research study.

Ethical approval for this study was given by QMU Research Ethics Committee (see Appendix 5) and all participants were treated according to the strict code of ethics required for membership of the Society of Homeopaths. This makes specific reference to issues such as naming the remedy, confidentiality and physical contact with patients. It is also specifically stated that homeopaths should not advise patients to discontinue conventional treatment or give any advice which might lead the patient to take action which could be detrimental to their health.

All data relating to homeopathic consultations and patient details was securely stored according to the requirements of the Society of Homeopaths. All data must be kept securely for seven years and at the request of the patient forwarded to a homeopath of their choice if they seek treatment elsewhere. After seven years data is securely destroyed.

All study participants gave informed consent and all were assured of anonymity (see Appendix 7). They signed a consent form and were provided with contact details of a named individual at QMU who was an independent advisor for the study (see Appendix

6). The participants could contact the named individual to discuss the research study, if required.

#### **2.5.3.3 Review of information for participants**

A review was carried out of the information to be given to participants and the questionnaire for MYMOP. Ten volunteers in the 55+ age group, with ages ranging from 55 to 70 read the information sheet and completed the questionnaire. These individuals did not go on to participate in the study.

The information sheet was thought to be clear, professional and accessible by those taking part in the review. One respondent commented that she would feel confident taking part in the research after reading the information sheet. It was felt that the spacing or print size could be larger in view of the age group of the study participants. It was suggested that the questionnaire could be re-formatted to ensure that questions and responses were on the same page. An explanation of MYMOP was also requested. As this questionnaire is covered by a copyright agreement, a cover sheet was added to take account of these comments.

#### **2.5.3.4 Recruitment process**

Participants were recruited by a planned advertising process. Initially, information about the research was sent out using e-mail. Information was sent out to people known to the homeopath/researcher, but excluded from the study, and they were asked to forward the e-mail to anyone who might be interested in taking part. A further e-mail was sent via the QMU moderator to all staff at the university, again asking them to forward the e-mail to anyone they knew who might be interested in taking part. The rationale for this approach was that people were more likely to volunteer to take part if there was a personal recommendation from someone who knew the homeopath, or a connection with a well

regarded institution such as a university. There was a risk with this approach that participants would come from similar backgrounds and share common beliefs about health and CAM, but there was also a random nature to the distribution of the e-mail and this did produce a very diverse group of individuals who volunteered to take part in the study.

Further recruitment was planned using advertisements placed in local community centres and local newspapers, specifically those related to health issues or the older generation. This proved to be unnecessary, but contacts made through the Centre for the Older Persons Agenda at QMU included information about the study in their newsletter (April 2008).

The approach used to recruit participants for this study has connections with the recruitment system called ‘snowballing’, in which existing participants recruit subjects from among their acquaintances (Wilmot 2005). The sample group grows like a snowball as a result and research data builds up as the cohort grows. This approach is often used in hidden research populations where recruitment might be difficult. In this study, the snowball approach was not the main recruitment method, although some participants did inform people known to them that the study was taking place. All participants in this study contacted the researcher directly to make enquiries about taking part in the study and their participation remained confidential.

Individuals who made enquiries about taking part in the study were provided with an information sheet, internet website addresses for further information about homeopathy and the opportunity to ask questions about the research project and homeopathy (see Appendix 6 *Information sheet for participants*). Individuals who decided to take part in the study were asked to sign a consent form at the first appointment (see Appendix 7). No screening of potential participants took place, other than to check that they met the inclusion and exclusion criteria for the study. The potential bias in self selection for this type of study was acknowledged.

### **2.5.3.5 Information given to participants**

Information given to participants in the research study was the same as that used by patients consulting the homeopath/researcher. Information about homeopathy is available on the website [www.homeopathyedinburgh.co.uk](http://www.homeopathyedinburgh.co.uk) or from a leaflet describing homeopathy and the nature of homeopathic consultations. A leaflet was also provided with each prescription of a remedy to explain how to take the remedy and possible outcomes. Participants were given a pre-printed form to record the effects of the remedy. A letter was sent with the remedy when it was posted to a participant's home address. Additional documentation for the study included items such as appointment cards and labels on homeopathic remedies.

At the beginning of the first consultation an explanation of the philosophy and practice of homeopathy was provided (see Appendix 8). The information was provided as part of the routine practice of homeopathy, ensuring that patients have an understanding of the treatment they are about to receive. It was also felt to be important for research participants to receive standardised information about homeopathy. This would allow evaluation of the importance of this information in any outcomes of the study and also any judgments they made about the process of treatment.

### **2.5.3.6 Conduct of homeopathic consultations**

Each participant in the study attended four appointments. The intention was that these appointments would be spread over a period of about six months. For most participants this was an appropriate timescale but for some participants this timescale was not achievable because of work or personal issues. Dates of actual appointments are recorded in Appendix 10. The initial consultation lasted one and half to two hours. The three follow up appointments lasted about one hour and took place at roughly monthly intervals. Participants were not charged a fee.

All consultations took place at the homeopath/researcher's clinic in the Murrayfield area of Edinburgh. The property is similar to houses used in the past by medical professionals who had a clinic in their own home. The consultation room is comfortable and decorated simply to give a calm but professional image. The patient and homeopath sat at right angles to one another. Notes were taken by the homeopath on a laptop computer.

Consultations were confirmed by letter or e-mail and information about the process supplied to all participants with this confirmation. Participants were able to bring a friend or relative but anyone who accompanied them was asked to sit in another room for part of the consultation. Participants were welcomed to the clinic by the homeopath and invited into the consulting room. They were asked to complete the consent form and the MYMOP and SF-36 questionnaires on arrival. Tea, coffee, juice or water was offered to participants. This was prepared while they completed the questionnaires in order to leave them alone to concentrate on answering the questions. They also completed a form providing personal details, such as name and address, and also details of past illnesses, medical treatment and current use of medication. Participants were then introduced to the consultation process.

The consultation began with a brief account of how homeopathy was discovered, and this was used to identify the process, and the type of questions which are asked in the consultation. The script for the explanation of homeopathy and the research process is provided in Appendix 8. The main topics to be covered in the consultation were defined as current symptoms, health history, family health history, lifestyle and personality, ending with a 'tour round the body' checking for any missed symptoms. It was stressed that the focus would be on the individual's experience of ill health, so small details were relevant. Discussion of lifestyle focused on the way the individual reacts to life events and health issues, rather than what the individual does to preserve health. Participants were invited to ask questions after this explanation.

The first question of the homeopathic consultation invited participants to describe their current symptoms. They were encouraged to continue speaking for as long as possible,



regardless of whether responses seemed relevant or covered the topics outlined at the beginning of the consultation. When the participants seemed to have said all they wished to say, questions were asked to reveal more detail and to cover topics not already mentioned. It was important to find out when the current symptoms began, what made them better or worse and the detail of symptoms. A pro-forma for case taking and reminders of points which can be raised if they are relevant to the case was used for recording patient responses and providing a reminder of issues that are important to a homeopathic case. The pro-forma was divided into the key topics outlined above and sub-topics which are commonly discussed in homeopathic consultations. This is not a prescriptive document and is merely used as a reminder for the homeopath and a resource for recording information in a semi-structured way. In some cases participants simply continued to talk and therefore only the first section of the pro-forma was used.

The consultations ended with ‘a tour round the body’ as patients were asked to summarise any physical symptoms working from the head down. This is a useful way of checking for symptoms that the participant might have missed and covering more sensitive and personal issues such as problems of a sexual nature or details of bowel movements. It also served as an indication that the consultation was coming to an end and helped participants to move away from emotional issues. This had a ‘settling’ effect in most cases. This was followed by an explanation of what would happen next and an opportunity for participants to ask questions. The next appointment was arranged to take place approximately one month later. Participants were shown to the door and reminded to ‘keep in touch, that’s the most important thing’.

The approach used for homeopathic consultations is recommended by Samuel Hahnemann in *The Organon of Medicine* (1810). He requires the homeopath to be an unprejudiced observer, listening to patients without commenting on their situation. This approach was used as much as possible in consultations in this study, but in practice it can seem unfriendly and even unfeeling to simply listen without comment. It can, therefore, be helpful to show sympathy or ask participants how they felt about a particular experience that seemed important to them. Examples of common experiences

discussed with patients of homeopathy were given occasionally, or further questions posed in an attempt to get more information from participants about their situation. Participants who cried during the consultation were offered tissues and time was given to acknowledge their distress. They were also offered the opportunity to take a break. The aim throughout the consultation was to focus on the story of the individual participant and every attempt was made to remove distractions, including any aspect of the conduct of the homeopath which might disrupt the flow of the participant's narrative.

The subsequent consultations followed the same approach, but began by asking about the participant's experience of taking the homeopathic remedy and focused on any changes in their health and well being as a result of homeopathic treatment. A pro-forma was also used for follow up consultations to provide a reminder of key points to be covered and used as a template for typing up commentary made by participants in the consultation.

The semi-structured interview asking participants about their experience of homeopathic treatment was conducted at the end of the fourth and final consultation. Participants were offered a break before starting the interview and then the process for conducting the interview was explained to them (see section 2.4.1.2 *Semi-structured interviews*).

As consultations are entirely confidential, the homeopath can be left with feelings about the participants' stories that cannot be shared. Experience and professional development help practitioners to manage this type of situation as well as possible. The use of a reflective journal and the support of supervisors is also important. An external advisor on homeopathy, Ishbel Bertram, a qualified homeopath and lecturer in biological sciences agreed to be the homeopathic adviser for the study and in addition provided a supportive supervisory role. She was not given any confidential information about participants and was only involved in general discussion about issues relating to remedies, self care and the role of the homeopath.

## **2.5.4 Management of homeopathic treatment process**

Homeopaths are required by their regulating body to manage all aspects of the homeopathic treatment process according to ethical guidelines and professional good practice. Information gathered in a homeopathic consultation is confidential and must be recorded and stored securely.

### **2.5.4.1 Medical information**

Identified medicines used by participants were checked for side effects, in order that the symptoms to be treated were identified separately from the effects of medication. Participants were not given advice on medication, but were encouraged to discuss the use of specific medicines with their doctor. Some participants disliked taking medication or disliked the side effects of particular drugs and hoped that homeopathic treatment would allow them to use less medication. Their desire to stop taking the medicines was acknowledged and a clear statement was made that they should discuss this with the prescribing doctor.

Many patients seeking homeopathic treatment have already had extensive tests and a range of conventional treatments. Information about these interventions is very valuable in planning homeopathic treatment. In this study, participants recorded information about this at the first consultation on the form for patient details. Those patients who had not consulted a doctor before coming to a homeopath could be advised to go to their doctor and ask for specific tests which relate to their symptoms. If there are symptoms which may be a sign of a life threatening illness, such as unusual bleeding, the patient would not be treated with homeopathy until tests had been carried out to ascertain the cause of the symptom. In this study this was particularly relevant for one participant who was advised to see her doctor because she was experiencing extreme breathlessness on exertion.

### **2.5.4.2 Record keeping**

All records of participant consultations were retained on computer and paper files and securely stored. Only the homeopath/researcher had access to these documents. They were not anonymised to ensure that participants were always easily identifiable and prescriptions were correctly recorded. Case notes were kept for each participant for each appointment. Personal details were also stored including records of past medical treatment and current use of medication. Analysis of case notes was stored with each set of case notes and copies of any e-mails sent by participants or records of telephone calls. A summary sheet for each participant, including contact details and remedies prescribed was stored at the front of each file for easy access in the event of participants making contact between appointments.

### **2.5.4.3 Prescription of remedies**

Notes taken during the consultation were not verbatim accounts of what was said, but participants' use of language was recorded and the account they gave of their health and life experiences was recorded as closely as possible to the original. These accounts were used to select a remedy that fitted most closely the needs of the individual. Analysis of case notes was done through close reading and also the use of the computer software Cara (see sample in Appendix 2).

The selected remedy was prescribed in LM potency (except for acute prescriptions, given in 30c potency in tablet form) using dropper bottles and granules placed in a mixture of water and alcohol (except for one participant who was allergic to alcohol). The prescription was posted to participants and a leaflet giving information about how to take the remedy was included in the mailing. A record sheet for noting any changes that occurred after taking the remedy was also included in the mailing, and a personal letter,

highlighting the need to observe any changes carefully and to contact the homeopath with any queries or concerns.

Remedies were purchased from Helios pharmacy in London and are stored according to their advice. A table of remedies prescribed is included in Appendix 11.

#### **2.5.4.4 Self care**

Homeopathy has been defined as a complex intervention and one aspect of the intervention that is considered in this study is the use of self care methods to improve health and well being.

The approach to self care taken in this study was to encourage participants to identify self care measures that were important to them as individuals and to discuss the value and benefits that they believed would result from this self care measure. If additional information or explanation about self care was requested by participants this was provided. The leaflet which accompanied remedies posted to participants also included a section on self care.

#### **2.5.4.5 Contact with participants**

Participants were frequently encouraged to ‘keep in touch’ and it was stressed that this was an important part of the process. After the first appointment, participants were asked to phone or e-mail to give information about the effect of taking the remedy. It was stressed that individual responses to remedies vary, but if the correct remedy was prescribed they would notice something happening. They were particularly encouraged to make contact if there was no response to the remedy in order that the prescription of a different remedy could be considered.

All contacts from participants were valued and responded to within 24 hours. All replies were warm and encouraging and accepting of all information provided. All copies of e-mails containing information about participants' health or well being were stored securely with their case notes.

Participants who chose not to make contact were sent an e-mail or telephoned after two weeks and simply asked, 'How are you?'

#### **2.5.4.6 Conclusion of research contact with participants**

At the last appointment, participants were thanked for their contribution to the research and reassured that they could continue to receive advice and treatment if they needed it. This was confirmed by letter and brief e-mails were sent to participants on two occasions after the last appointment asking how they were and reminding them that further treatment could be provided. Ten participants have taken advantage of this offer, either attending for further appointments or requesting more homeopathic remedy by telephone or e-mail.

#### **2.5.5 Analysis of research data**

The description of each research method includes details of the chosen approach to analysing each type of data collected. The embedded design chosen for this study identifies primary and secondary data. It does not combine results as in the triangulation research method, which presents a single outcome based on combining outcomes for each data source. The outcomes for quantitative and qualitative data are therefore presented separately in the results section. The pragmatic approach to research values different perspectives on the same issue and may not include a summary outcome.

Although the analysis of each type of data is detailed separately in this study, in order to answer the research questions there is some value in presenting data together. The first method used to achieve this is simply to present a summary or exemplar for each participant for each data collection method in a table. This is included at the end of each set of results and additional results added progressively. Outcomes from the research are therefore presented visually and comparisons can be made across each line of the table. Although this is not a direct comparison of like with like, it does give some indication of how individual participants responded in each research method.

Qualitative data is difficult to present in terms of outcomes as it includes the richness of individual experience and the diversity of viewpoints valued in a pragmatic approach to research. However, in the interview setting participants were asked some closed questions, followed by an invitation to explain their response. The closed questions provided an opportunity to get a more definite view from participants about the impact of homeopathic treatment and the aspects of treatment that they believed made a difference to their health and well being. Most of the analysis of the qualitative data is thematic but the responses to the closed questions in the interview setting provide some responses that can be linked to other data sources. For example, participants were asked about their beliefs about homeopathy and the placebo effect and these responses can be cross checked with measures of improvement in quantitative data. This has the potential to reveal how many people who believed in homeopathy before treatment showed an improvement in perceived health and well being in results from the questionnaires.

Quantitative data can be analysed in a variety of ways. The design of this study makes use of questionnaire responses to support qualitative data. The data collected from SF-36 questionnaires was analysed using a norm based score for a composite of items in the questionnaire. These are presented under ten headings for different aspects of health and well being, including a compilation of all participant responses under the headings Physical Component Summary and Mental Component Summary. Further analysis of this scored data was attempted using statistical analysis to assess any significance in the

results obtained. Results from this approach are limited by the small number taking part in the study but provided a further opportunity to interrogate the data.

MYMOP is a simpler questionnaire than SF-36 and is analysed by inputting the data to a computer spreadsheet which offers numerical analysis of scores provided by participants on a Lickert scale. The four key items of information provided by participants on MYMOP can be very different, ie two symptoms they wish to improve using homeopathy, one activity they would like to resume, and their perception of their well being in the previous week. The potential inconsistencies in the data recorded and the difficulty in summarising MYMOP data is considered further in *Chapter 4: Discussion*.

In summary, the analysis of the different data collection methods was carried out separately in order to retain the richness of data and the individual participants' perceptions of the experience of homeopathic treatment. Presentation of selected outcomes in a comparative table is provided to show connections or differences between data collected for each participant. Limited analysis of combined data methods is carried out to explore the possibility of connections or differences in individual responses to different data collection methods.





## **CHAPTER 3: RESULTS**

### **3.1 INTRODUCTION**

This chapter presents the analysis of data gathered during this research study. This includes:

- ❑ demographic information about participants
- ❑ interviews with participants
- ❑ participant case notes
- ❑ practitioner reflections
- ❑ data gathered from MYMOP questionnaires
- ❑ data gathered from SF-36 questionnaires

## **3.2 DEMOGRAPHIC INFORMATION ABOUT PARTICIPANTS**

Twenty participants were recruited to take part in this research study. They were recruited through e-mail promotions of the research and recommendations from other participants or others who had experience of homeopathy. The participants were aged between 55 and 70 years, with an average age of 60. Sixteen of the participants were female and four were male. They came from different parts of Scotland, including several major cities and rural areas. Most participants were professional people during their current or past working life, including directors of organisations, university lecturers, a minister of the church, teachers, therapists and administrative staff. One participant was retired and another retired through ill health from his job as a lorry driver.

Participants presented with a range of different symptoms. These are described in more detail in section 3.4 and 3.6, but initial symptoms described by participants included joint pain, depression, anxiety, sleeplessness, lack of energy, headaches, hot flushes, sinusitis and acute conditions such as shingles. Most participants were taking conventional medication and/or other complementary therapies to treat symptoms and underlying medical conditions.

During the period of treatment from January 2007 until August 2008, some participants experienced a range of additional health problems, including acute illness and dental emergencies. Some participants also experienced personal crises such as bereavement, ill health of a family member and stressful situations at home or at work during the period of treatment.

### 3.3 INTERVIEWS WITH PARTICIPANTS

The purpose of the participant interviews was to gain information about their experience of homeopathy. This related to the research questions:

- ❑ Is homeopathy perceived to be effective in improving health and well being and quality of life in the 55+ age group?
- ❑ What are the common themes in the experience of homeopathic treatment described by participants in this study?

The interview questions were designed to take account of research into the impact of a range of variables on patient experiences of CAM. These included participants' beliefs about health and homeopathy, influences such as the relationship with the homeopath, context and conduct of consultations and responsiveness to homeopathic treatment. (See *Chapter 3 Methodology*)

The selection of themes was based on their importance to participants and the frequency with which comments were made on the same topic. The process for selecting themes is detailed in Section 2.4.1.1 and an example of analysis of an interview question is provided in Appendix 9.

The themes selected were:

- ❑ perceived outcomes of treatment
- ❑ the therapeutic relationship
- ❑ beliefs about health and homeopathy
- ❑ comparisons with other health care provision

The sub-themes were selected because they highlighted aspects of the themes which supported their importance and illustrated the way in which participants had expressed their views about homeopathic treatment.

The themes and sub-themes are detailed in the following table.

**Table 3: Themes and sub-themes revealed in participant interviews**

<b>Themes</b>	<b>Perceived outcomes of treatment</b>	<b>Therapeutic relationship</b>	<b>Beliefs about health and homeopathy</b>	<b>Aspects of the treatment process that were valued by participants</b>
<b>Sub-themes</b>	Perceived improvement in emotional well being	Honesty in relating their story and symptoms	Knowledge of homeopathy	Venue for treatment
	Improvement in physical symptoms	Reviewing life experiences, making connections	Beliefs about health and healing	Value placed on contact with the homeopath between appointments
	Commentary on 'side effects'	Non judgemental acceptance of their story	Beliefs about reasons for changes in health	The approach used in the homeopathic consultation
		Greater understanding of their life story or enlightenment	Impact of being part of research study	Direct comparison with conventional treatment

These themes were selected on the following basis:

- ❑ The participants' perception of the outcomes of treatment seems the most important theme to explore initially as this is likely to influence how they felt about the process and the themes that they highlight. It is also a direct response to the research question on the efficacy of homeopathy.
- ❑ The therapeutic relationship is also important as it may influence the outcome of treatment and have a bearing on how the process is perceived. It is also likely to

have a bearing on the success of the treatment process and the participants' commitment to continuing the research.

- ❑ The beliefs held about homeopathy and health may have an impact on perceptions of the effectiveness of homeopathic treatment and these were explored in the interview questions.
- ❑ The final theme selected relates to specific aspects of the homeopathic experience which were valued by participants. The participants were not asked to make a comparison with conventional health care but spontaneously used their experiences of visits to hospitals and GP's to highlight what was important to them in the homeopathic treatment process.

An explanation of their significance to the research questions is provided in the following account of each theme.

### **3.3.1 Perceived outcomes of treatment**

The most important information provided in the semi-structured interviews with participants related to the research question on the effectiveness of homeopathy in improving perceptions of health, well being and quality of life in the 55+ age group.

All 20 participants took part in the four consultations and 19 participants took the homeopathic remedy. During the semi-structured interview conducted at the end of the final consultation, 18 of the 19 participants who took the homeopathic remedy described improvements in their health. Of these 18, some reported very definite improvements and others reported improvement in one or more specific aspect of their health. Changes in health were described in terms of improvement in emotional well being and physical symptoms, as well as what they described as 'side effects'. These sub-themes are explored in more detail below, using direct quotations from the transcripts of participant interviews. (Transcripts of the complete interviews with line numbers are provided in the attached CD-rom.)

### **3.3.1.1 Perceived improvement in emotional well being**

Participants who commented on an improvement in emotional well being experienced a sense of greater calm, ability to cope with life and in some cases a return to focusing on issues which were important to them. No participants commented on negative changes in their emotional well being as a result of homeopathic treatment.

The comments included descriptions of feeling better emotionally:

- “I felt myself calmer... when I first came I really was very anxious... it’s just like chalk and cheese now” (Participant 1, Line 101)
- “there was a gradual moving away from my feeling of utter disconnectedness back to a greater sense of commitment to life in general” (P9 L61)
- “I’m more on an even keel now” (P11 L40)

They also commented on being able to cope with problems or stressful life events better:

- “I coped better with various problems” (P3 L51)
- “It helped me to cope better in the situations that I found myself in” (P17 L38)

Some comments were less specific but indicated a sense of improvement in emotional well being:

- “I’ve made definite progress” (P5 L48)
- “It had a positive effect on the house” (P6 L49)
- “It’s just been incredible, what an improvement” (P7 L55)
- “the general feeling of goodness and feeling well” (P14 L62)
- “it has taken me back to being relaxed spiritually and interested” (P18 L39)

Their comments provide evidence of perceived improvement in well being and quality of life during the period of homeopathic treatment. The comments seem to suggest an improvement in the ability to cope with stressful life experiences as well as a general feeling of well being. This ability to cope and feeling of well being was experienced very differently by individual participants. For some it was a question of feeling out of balance before, and improvement in well being seemed to restore the balance that had been lost. For others there was a specific indicator that they felt better emotionally, for example the ability to get on with their role in life or to connect to others, or to feel a return of spirituality. The implication of these accounts is that something which had been lost to these individuals had been restored. They were able to recognise the change and the familiarity of the positive feelings that returned during homeopathic treatment.

### **3.3.1.2 Improvement in physical symptoms**

The second sub-theme relating to the research question on outcomes of homeopathic treatment related to perceived changes in physical symptoms. Participants who commented on changes in physical symptoms reported on symptoms they had identified at the initial consultation but also on unexpected changes in their health:

- “I did not get constipated when I went on holiday” (P3 L47)
- “the pain actually went away... coming down the stairs I had to do them kind of one at a time, but I can still run downstairs now” (P4 L42 and L103)
- “you have no idea just how tired you are...until you’re not” (P7 L62-63)
- “took away my headaches” (P8 L41)
- “it minimised the effects of the shingles...blisters did not materialise” (P9 L56)
- “I’ve got much more mobility and I can actually put my socks on” (P10 L48)
- “I don’t now have the pain in my arm or neck, so I’m able to cope more with different parts of my life” (P11 L80)



- “poor sleeping...has definitely improved” (P13 L50)
- “heat and flushes actually did began to subside... a wonderful sensation, something is working” (P20 L53 and L55)

The improvement in physical symptoms during homeopathic treatment is referred to in terms of feeling better but also in relation to quality of life and ability to carry out tasks that were difficult when participants were experiencing the symptoms. The restrictions on the way participants live their lives is an indicator of quality of life. Increased mobility, reduced pain and ability to sleep better all contribute to a more comfortable life style.

### **3.3.1.3 Commentary on ‘side effects’**

The use of the term ‘side effects’ to describe symptoms that occurred after taking homeopathic remedies relates to the conventional use of the term in relation to pharmaceutical medicines. This was the term used by some participants in the study, but this experience would be described by a homeopath as an aggravation of symptoms or a return of old symptoms.

In homeopathic treatment there may be evidence of symptoms which are thought to be caused by the body’s own healing capacity. In homeopathic philosophy this is described as an ‘aggravation’ when a patient gets slightly worse before getting better. It is also described as direction of cure when symptoms appear on the surface of the body as if moving illness to the least harmful sites on the body. The relevance of the reports of such homeopathic phenomena is that participants were aware that something was happening and they were often surprised by it as if it had not been part of their expectation of treatment. This is important when assessing the impact of beliefs about health and homeopathy on outcomes of treatment as the unexpected is not likely to be part of a belief system that could influence perceptions of healing.

Some participants described what they called ‘side effects’ of homeopathic treatment, such as worsening of existing symptoms, bouts of sneezing and skin eruptions.

- “fierce return of symptoms... which wasn’t pleasant for two days...but certainly gave me the impression that something was happening” (P3 L48)
- “the pain at that point was quite excruciating...after sneezing for probably half an hour or more, the pain actually went away. And that was really quite an experience.” (P4 L40 and L42)
- “side effects from it, spots on the nose and face” (P6 L46)
- “I’ve had lots of sessions of sneezing...I’ve had these occasional rashes on my lower arms” (P13 L52 and L53)
- “the plukes, the plukes that was interesting, and the eruptions in other bits of my body” (P14 L58)

Participants made connections between these symptoms and taking a homeopathic remedy. This is evidence of physical symptoms which they perceived to be related to their treatment process. Although the symptoms, such as sneezing or spots, may have been experienced before, participants stated clearly that in this case they were related to the remedy and their experience of homeopathic treatment. These types of reaction to a remedy are part of the homeopathic philosophy of cure and are therefore regarded by homeopaths as important in assessing the outcome of treatment.

### **3.3.2 The therapeutic relationship**

An important theme for many participants was the value they placed on the relationship with the homeopath. This was divided into the following sub-themes:

- ❑ honesty in relating their story and symptoms
- ❑ reviewing life experiences and making connections
- ❑ non judgemental acceptance of their story
- ❑ greater understanding of their life story or enlightenment

Participants expressed satisfaction with the relationship with the homeopath and valued specific aspects of the consultations. Improvement in health and well being may be attributed to this relationship so it was important to find out from participants what impact they believed the relationship had on the outcomes of treatment.

There were different views on the importance of the therapeutic relationship to the outcome of the treatment. Some participants used words like “certainly” and “definitely” to describe the positive effect of the relationship with the homeopath on their treatment. Other participants used words like “probably” and “possibly” and others stated that they thought it had no effect on the outcome of the treatment. All valued the opportunity to have a good relationship with the homeopath but expressed this in different terms:

- “these meetings have helped on the whole” (P2 L117– did not take remedy)
- “a good relationship with anybody never hurts... but as to making a difference to the outcome of the therapy, no” (P7 L133)
- “I don’t know if it’s really made any difference. I mean it’s nice to come and talk” (P8 L67)
- “I’ve liked coming here to see you and talk...if I hadn’t liked being here I probably would have found a way to tell you that I wasn’t going to do it” (P15 L63)
- “I doubt whether everybody could have got as much out of me as you’ve managed to do” (P14 L99)
- “if I hadn’t related to you I might not have come back” (P20 L100)

In describing the relationship with the homeopath, similar words and phrases were repeated by participants. These included ‘trust’, ‘easy to talk to’, ‘very sympathetic’, ‘not judgemental’, ‘respect’ and ‘close relationship’ (see attached CD-rom for complete transcripts of interviews). Accompanying these descriptions of the relationship were comments about the need for a trusting, open relationship to facilitate the telling of a personal story to another individual. This may relate to the value placed on the opportunity to talk about life experiences but it is not clear if it had an impact on their

health, quality of life and well being. It is likely that it had an important effect on the ability of the homeopath to gain relevant information from participants in order to prescribe a well indicated homeopathic remedy. Homeopaths rely on the story told by their patient to get relevant information relating to remedy choice. If someone is reluctant to talk about their experiences then it can be difficult to prescribe the correct remedy. An example of this is the experience of abusive relationships. If this remains undisclosed a helpful remedy for those who have experienced this, such as *Staphysagria*, might not be considered.

### **3.3.2.1 Honest accounts of participants' experiences**

The relationship of participants with the homeopath may influence the feedback given in the consultations. Participants may wish to please the homeopath by reporting positively on the outcomes of treatment. Another possibility is that they may overstate their experiences, or place emphasis on particular aspects of the experience. Participants in this study stated that they valued the trust engendered by the therapeutic relationship which resulted in greater openness. They consistently reported that they had given honest answers to questions in the consultations and their answers had been important to them as individuals.

- “I wasn’t trying to please anybody or make it fit your research or anything like that” (P12 L103)
- “I didn’t feel I had any reason to impress or please her” (P13 L124)
- “I never felt led by you...I’ve found it to be a very open exchange” (P15 L89)
- “you didn’t put words into my mouth... I felt confident enough not to feel that I had to agree” (P19 L99)
- “I don’t think I was editing to make what I said fit... I was trying to be truthful” (P20 L143)

The role of the homeopath as an “unprejudiced observer” (Hahnemann 1810 aphorism 6) may provide a particularly valuable opportunity for individuals to express what they really feel. Classical homeopathy is based on Hahnemann’s principle of allowing individuals to tell their story in their own way without interruption or judgement being made on what is said. This approach may have offered participants in this study the opportunity to speak openly about their experiences and thus to feel that they had been as honest in giving their answers as it was possible to be. The homeopathic consultations are also of a sufficient length to allow participants to raise issues that are important to them and for the homeopath to ask detailed questions about the participants’ health and life experiences.

### **3.3.2.2 Reviewing life experiences and health issues**

Participants stated that the experience of telling their story was valued as an opportunity to review past experiences and make connections between life events and health and well being. This led them to question past experiences or interpretations of events. It also provided an opportunity for them to revisit past sadness or trauma and reflect on the impact it had on their lives.

- “Things you don’t think about you start to question and think more... it made me think a lot about myself and things that I’d done in the past” (P1 L37 and L48)
- “a safe place in which to explore things... so delighted with the opportunity to revisit some of these older things which I wanted to come out” (P5 L43 and L189)
- “I was quite surprised by the things that it kind of brought back to my mind...and I’d never really thought about...you think a bit more about things that are happening to you and your reaction to them” (P8 L24 and L36)
- “It’s a way of examining your own feelings... a bit of a luxury being able to open up to someone” (P10 L25-26)

- “you also gave me questions which made me think and look at myself...it brings out feelings that have been hidden” (P11 L88 and L28)
- “it’s a learning experience...it makes connections” (P12 L27 and L37)
- “it was quite liberating...and made me think that there are connections down the line which turn you into what you are...we are all complex anyway so you need an intervention that is similar” (P14 L36-48)
- “almost a cleansing of your soul and certainly a telling of your story” (P14 L31)
- “It’s made me explore why I have these symptoms and why I have them in relation to my life and lifestyle” (P17 L25)

There was no clear evidence that this process had an effect on the outcome of treatment but participants described the benefits of exploring their past experiences and their feelings. It was apparent at subsequent consultations that participants moved away from discussing past events and focused more on present experiences. For some participants this also included leaving behind some of the negative emotions that accompanied their memories. It was not clear if this process and the resulting change to a more positive state had an impact on health and well being which was separate from the effect of the homeopathic remedy.

### **3.3.2.3 Non-judgemental acceptance of participants’ narrative**

The role of the homeopath as an unprejudiced observer has already been referred to. This role involves listening to the patient’s account of their health and life experiences and only asking questions when the patient has said all he or she wishes to say. This provides an opportunity which some people find unusual, to be listened to without interruption or commentary.

In this study participants valued the openness of questioning and the non-judgemental acceptance of what they said:

- “you could take my face value, just as you appreciated your own, expecting neither of us to change” (P5 L136)
- “you nod and wink at whatever I’ve said, and not said, ‘Oh my God’ so there’s no feeling of making a judgement” (P13 L96)
- “I’ve been able to tell you far more than I would divulge to a friend” (P10 L98)
- “the absolute non judgement...for me that was really important” (P20 L39)

They also referred to discussions about topics that they would not normally have discussed:

- “made to think about certain things” (P2 L31)
- “I was surprised that I talked about stuff that I very rarely mention. I’m sure very few people know about it” (P7 L163)
- “discussing the several problems other than the pain, you know, played important part in the treatment as well” (P16 L67)

The depth of the response was noted by some participants:

- “...made me think more deeply about it or another aspect of it” (P2 L161)
- “promoted thoughtful answers...things we might not expect to be relevant turn out to be very relevant” (P5 L125 and L28)

This experience of openly talking about aspects of their lives that they may have kept to themselves seems to have been important to many participants in the study. They were not clear what impact this had on their well being, only that it was a valuable experience and part of the healing process that they were going through, described by some participants as a ‘journey’.

### 3.3.2.4 Enlightenment

The participants highlighted an aspect of the homeopathic treatment which some of them described as enlightenment and others described in terms of increased self awareness and an opportunity to review and explore their life experiences. As with the comments made about the therapeutic relationship, it is not clear how important this was in terms of improved health and well being, but it was significant that several of the participants highlighted this as an important part of the homeopathic experience.

Participants spoke of greater understanding of their life story in the following terms:

- “It just made me more aware...enlightening.” (P8 L26 and L29)
- “I’ve found it very supportive in the way you’ve interpreted homeopathy to me and applied it to me” (P9 L153)
- “the whole experience has been enlightening...come to terms with a lot more” (P11 L32)
- “it’s been enlightening” (P14 L29)
- “it combines the healing experience with...reflection and stimulation and thoughtfulness and it’s very good” (P18 L33)

This final quotation provides a helpful summary of how one participant viewed the combination of increased self awareness and healing. Not all participants were as clear about the meaning of the experience for them as individuals, but many made reference to the reflective nature of the homeopathic consultation and placed value on the opportunity to share and explore experiences and emotions.



### **3.3.3 Beliefs about health and homeopathic treatment**

The influence of the beliefs of individuals on their health is an important factor to consider when measuring the outcomes of a study of this kind. In order to answer the research question about the perceived efficacy of homeopathy it is necessary to identify other possible reasons for the outcomes of treatment. The nature of a complex intervention is that different factors included in the intervention may be responsible for changes in individual perceptions of health and well being.

There were different types of responses to questions about beliefs about health and homeopathy and these were grouped under the sub-themes:

- ☐ knowledge about homeopathy
- ☐ beliefs about health and healing
- ☐ beliefs about the reasons for changes in health and well being
- ☐ the impact of being part of a research study

#### **3.3.3.1 Knowledge of homeopathy**

Participants were asked about their beliefs about homeopathy and any past experience of homeopathic treatment in order to see if there was any connection between outcomes of treatment and their knowledge and beliefs about homeopathy before starting treatment.

Eight participants stated that they believed in homeopathy before taking part in the study. Six participants said that they had no view on homeopathy before treatment, or no knowledge about it, and had not thought about it before. Five participants said that they had an open mind about homeopathy. Eleven participants had some experience of homeopathy, either through a relative or friend or using remedies themselves. No one had had recent constitutional homeopathic treatment. One participant looked up homeopathy on the internet.

All participants were given written information about homeopathy (see Appendix 6) and were told at the first appointment about the origins and mode of action of homeopathy. When asked in the interview how they would describe homeopathy to someone who knew nothing about it, no one made reference to the written or spoken explanations provided before treatment began. One participant said that even after treatment he was still unsure of what homeopathy was. Six participants made reference to homeopathy as a holistic therapy. Three participants referred to it as a gentle, non-invasive therapy and four referred to it as an alternative to drug therapy.

In general, participants had a very limited understanding of the meaning of homeopathy and this suggests that their knowledge and beliefs before treatment did not affect the initial outcomes. It is possible that the information provided to participants about homeopathy was not easy for them to understand or remember, or the complexity of the subject is not easy to convey in brief explanations. It is also possible that the time of receiving information was a time when they were interested in their own health and explanations were a distraction at the start of the consultation. Two participants commented that they believed in homeopathy as soon as it started to work. This comment may be relevant as it suggests that the importance of a therapy is its ability to improve health and understanding the principles and philosophy is less important.

### **3.3.3.2 Beliefs about health and healing**

Participants were given an explanation of the placebo principle and the impact of beliefs on the outcomes of health treatments (see Appendix 4, Additional information to define terms or explain interview questions).

When asked about their view of the impact of their beliefs on the outcomes of homeopathic treatment, eight participants stated very clearly that their beliefs about health and the placebo effect were not a factor in improvements in their health.

This perception was justified in the following ways:

- “my own reactions... They’ve been subtle and gradual... the placebo effect would have been faster and clearer” (P5 L80-81)
- “If you don’t have any expectations... then it’s very hard to ascribe that to a placebo effect... I cannot stop my eyes being bloodshot...as if I’ve been on an all night bender... within days of starting the remedy... my eyeballs are white and no placebo effect can do that because I was not looking for it” (P7 L124 and L96-101)
- “I didn’t have any beliefs about homeopathy” (P14 L84)

One participant stated that if “one believes in something” (P3 L71) it has got a much better chance of working. Two participants expressed the view that it was necessary to be involved in the process and talking helped their recovery. One participant expressed the view that “the placebo effect would always be with anything” (P12 L64). Two participants expressed the view that they believed in it “from the moment that it worked” (P4 L68).

The range of responses to the question about the impact of belief on the outcomes of treatment, suggests that most participants did not consider that their beliefs were a factor in the outcome of treatment. This issue is considered further in *Chapter 4: Discussion*, but it is interesting to note here that participants took this question seriously and tried to analyse the impact of their knowledge and beliefs on their experience of homeopathic treatment. Although they were given information and definitions of terms such as ‘placebo’ they seemed to analyse their views using their prior knowledge of health and healing. This meant that the belief, for example, that the placebo would work more quickly was a belief based on past experience not information given during this study. The subtle nature of belief systems and knowledge held over many years about a range of health issues suggests that it is very difficult to assess the impact of beliefs on healing experiences.

### **3.3.3.3 Beliefs about the reasons for changes in health and well being**

In this study, homeopathic treatment has been defined as a complex intervention involving the homeopathic remedy, the therapeutic relationship and discussion of self care. These aspects of treatment were referred to during the consultations and at the interview at the end of the final appointment.

Participants were asked to give an opinion about the reasons for changes in their health. Eight participants said that it was a combination of the homeopathic remedy, interaction with the homeopath and self care.

- “from the greatest to the least, I would say remedy, interaction and self care... neither interaction nor self care would have been sufficient on their own to alleviate those specific symptoms” (P9 L160)
- “the biggest would be the homeopath because that was the catalyst that started it all, so the remedy without the homeopath or the homeopath without the remedy wouldn’t work...” (P12 L111-113)

Eight participants believed that changes resulted from taking the remedy and the interaction with the homeopath.

- “interaction with the homeopath and this made me think about ways to change my life and taking responsibility” (P11 L95)
- “overall I’m feeling better so I don’t care which has helped...overall the combination of the remedy and the conduct of consultations and what not have helped me” (P13 L132-135)
- “the actual person of the healer is very important” (P18 L104)
- “part of homeopathy is about talking” (P20 L163)

Eighteen participants stated that they believed the remedy had worked.

- “the remedy certainly did its trick” (P4 L116)
- “The remedy! The healing effect was the remedy” (P7 L173)
- “the actual remedy must have worked” (P18 L102)

One participant did not take the homeopathic remedy and believed that talking things over with the homeopath, self care and conventional medication for depression made a difference to her health.

Participants were asked about the effect of any self care that was discussed in the consultations. P2, the only participant who did not take the homeopathic remedy, reported significant use of self care measures discussed in the consultations, such as drinking more water, exercise and the concept of eating carefully selected foods as if they were medicine. Eight participants specifically stated that they felt that discussions of self care had made no difference to the outcome of treatment or their behaviour. Four participants stated that they felt their current self care was good. Three participants stated that they knew about self care measures but did not implement them. Six participants interpreted self care as talking about past trauma or issues that affected their health such as stress at work. They all stated that talking about these issues was helpful. Two participants said that because they felt better in themselves they had resumed previous habits of taking exercise. Two participants felt that they were more aware of what they did to improve their health as a result of discussions in the consultations.

These responses seem to suggest that the homeopathic remedy was regarded as a very significant part of successful treatment. For some participants this was linked with the relationship with the homeopath. For most participants the discussion of self care had no impact on their behaviour or the outcome of treatment.

### 3.3.3.4 Impact of being part of a research programme

Taking part in a research study can influence the behaviour of participants and the outcomes of the study. The level of care received in a research study can have an impact on individuals, as can the relationship with the researcher. Participants in this study were asked directly if they had been influenced by the homeopath/researcher and if they had been accurate in their descriptions of their symptoms and any changes that had taken place. Eighteen participants stated that they described their symptoms as accurately as they could and two participants said that they might have missed some information.

- “because you were doing it for a research thing I felt it was important to think about it and get it right” (P12 L95)
- “I didn’t consciously, not, or over report on anything” (P15 L82)
- “I didn’t have any sort of reason to say contrary to the outcomes I got” (P16 L86)
- “I wouldn’t describe things in a way that would be positive if people wanted them to be positive or the other way round” (P17 L83)
- “I’m guessing the research part also adds an element to it, there’s a sharpness to it, focus the mind” (P18 L70)

In this study, it seems that the research element enhanced the responses of participants as they felt some responsibility to provide an honest account of their experience.

It is also possible that participants in any research study are influenced by the fact that treatment is free and they are volunteers. This may lead to a lack of commitment to attending appointments or to dropping out of the study. Participants were specifically asked if the fact that treatment was free made a difference to their view of the treatment process. All agreed that this did not affect the treatment but placed value on the process and the research.

This was expressed in the following way:

- “research is a good thing to do” (P4 L123)
- “I feel you’d be the same whether you’re charging or not” (P5 L162)
- “the whole treatment process was carried out in a very professional manner... I didn’t undervalue the process because it was free which can be a tendency” (P9 L170-173)
- “I have felt it of sufficient value to me to travel up to Edinburgh four times, which is about 80 miles each time... and that is my cost so to speak” (P13 L145-147)
- “I thought you’re doing that research so I must give the most, the best of my ability to do it” (P16 L115)
- “I see you as a professional and you’re going to be professional whether or not you’re being paid” (P19 L114)
- “being part of research ... I was committed” (P20 L183)

Seven participants expressed gratitude for being part of the research programme. Five participants said that they would or had already recommended homeopathy to others. Nine participants spoke about how much they had enjoyed taking part in the research.

- “it’s been a very good experience” (P3 L142)
- “It’s been a journey... enjoyable” (P11 L118)
- “It’s a fascinating journey” (P12 L135)
- “I enjoyed taking part, thank you... what benefits I’ve reaped” (P20 L210 and L212)

The value placed on the experience seems to result from participants finding it an enjoyable and personally valuable experience but also having a desire to contribute to research of this type.

### **3.3.4 Aspects of the treatment process that were valued by participants**

Evaluating health care provision may involve assessing aspects of the process which are not defined directly as part of the treatment. In this study participants were asked about aspects of the experience that might have made a difference to the outcome of treatment or to their willingness to attend appointments. Their responses can be divided into the following sub-themes:

- ☐ venue for treatment
- ☐ value placed on contact with the homeopath between appointments
- ☐ the importance of being listened to
- ☐ direct comparisons with conventional treatment

#### **3.3.4.1 Venue for homeopathic treatment**

It is common for homeopaths and other complementary therapists to work from their own homes. This may add value for some users of CAM but for others it is preferable to attend a clinic or a more obviously medical venue. For this study, appointments took place at a home based clinic and participants were specifically asked if this made a difference to their perception of the treatment process. Although it might have been difficult for participants to state directly that they were dissatisfied with the venue, most provided a reason why they found it satisfactory or made comparisons with unsatisfactory health care environments.

All participants said that they preferred the atmosphere in a home based clinic. Fourteen participants used the following words to describe the feeling they had about the clinic: ‘calm’, ‘relaxing’, ‘comfortable’ and ‘pleasant’. One participant suggested that people might prefer the anonymity of a private house. Participants also made comparisons with other types of therapeutic setting.



- “I’d have been more reserved in an office” (P5 L173)
- “the feeling of there being time and less pressure than there might have been in a clinic type atmosphere was helpful” (P12 L129)
- “probably better than an office type office” (P13 L155)
- “it’s always nice to be in a pleasant environment, perhaps a home and a home office adds to that rather than a cold clinical surgery” (P17 L116)
- “I think you feel far more comfortable than going into a doctor’s surgery” (P1, L144)
- “a scruffy room in a hospital... and it was scruffy... and it was horrible and puts you in a very negative state, doesn’t give you confidence” (P19 L124)

One participant described the consultation room used in this research study:

- “it felt both comfortable and professional, nice, there was a nice settee to sit on, and even a nice cup of coffee, and it was comfortable, soft lighting, a very comfortable ambience and yet there was a sense of professionalism, a big solid desk... and you had your computer and you had diplomas on the wall and so there was a feeling of solidity and professionalism” (P9 L184-188)

In general, participants stated that they were at ease in the venue chosen for this study and many felt that it enhanced the experience of homeopathic treatment. This is relevant when considering the therapeutic environment for any treatment or research into health care issues. P9 summarised the key things that seemed important to her in the venue and her choice of language suggests that comfort and evidence of professional practice is important. The impact of this on a research study is also important as it is less likely that participants would have continued to attend appointments if they had been uneasy about the venue. As all participants attended all appointments and commented favourably on the venue it seems likely that it was appropriate for purpose and possibly enhanced the experience of homeopathic treatment.

### 3.3.4.2 Contact with the homeopath between appointments

There is no standard approach to offering advice and support between homeopathic appointments. The level of support offered is left up to the individual practitioner although most professional bodies and training organisations advise that clear boundaries should be set to avoid patients phoning late at night or making unreasonable demands of the practitioner. For this study, participants were encouraged to ‘keep in touch’ regularly by e-mail or telephone, particularly at the time of starting a new remedy or any crisis in their health or well being.

Most participants stated that it was reassuring to know that contact by phone or e-mail was available. Six participants specifically said that they did not make contact but even so, they were thinking about homeopathy because there was evidence that things were happening and they were taking the remedy regularly.

- “I’m not sure that contact by e-mail made any difference to the outcome of the treatment. I don’t think it did. I don’t want you to feel bad about that. (He laughed.) I think my brain was in gear to it. I didn’t actually need the reminder to keep my brain in gear with it because things were happening.” (P14 L114–117)

Four participants valued the use of e-mail as a way of recording what was happening and as a result increasing their awareness of changes which had taken place. Five participants valued the sense that they were being cared for and a stronger bond was being created with the homeopath. Three participants referred to the advantage of being able to make contact when things were not going well, particularly in the early stages of treatment.

- “fantastic because it was so quick...you felt better knowing that there were reasons for how you were feeling” (P1 L92)
- “it’s unusual in this day and age to get the sense that perhaps someone really cares about you one way or the other” (P13 L103)

- “I don’t think the doctor like you to e-mail them all the time” (P16 L78)
- “it was certainly useful when I had that nasty reaction to be able to contact you” (P17 L75)

It seems likely that the availability of contact with the homeopath was an additional benefit for participants, perhaps unlooked for as it is less common in other health care settings. It was seen as useful when trying a new therapy or when things were strange or difficult for participants. Those who did not make contact with the homeopath between appointments also seemed to value the availability of contact should they need it.

### **3.3.4.3 The approach used in the homeopathic consultation**

The approach taken in homeopathic consultations can seem very different from that taken by other therapists or a GP. Participants in this study highlighted some aspects of the consultation that they felt were important.

The initial homeopathic consultation lasts for approximately one and a half to two hours. The follow up consultation lasts approximately one hour. At both consultations the participants were asked detailed questions about many aspects of their health and life experiences. Participants in this study valued the thoroughness of this process.

- “the whole approach is very thorough and that also feels beneficial” (P3 L32)
- “the initial interview is lengthy, probing” (P9 L29)

One participant valued the involvement in the decision making process.

- “you did ask what I thought and I quite like that...sometimes GP wise...they don’t always want to tell you” (P13 L41)

Participants valued being listened to and feeling cared for.

- “the relationship was quite different to the relationship with a GP...where you wouldn’t expect to be listened to in anything like that depth” (P9 L91)
- “It felt like I was being cared for and I’m sure that played some part in the overall outcome” (P9 L90)
- “there is a caring feeling, which is nice” (P13 L97)

The calm and relaxing experience was mentioned by many participants.

- “a very calming and reassuring experience” (P16 L33)
- “relaxed, helpful, positive” (P17 L32)

These responses suggest that participants valued the opportunity to talk about their experiences in a calm setting. In general participants described the manner of the consultation as an additional support for them which allowed for greater openness and gave a sense of being cared for which they valued.

#### **3.3.4.4 Direct comparisons with conventional health care**

Participants were not directly asked to make comparisons with other forms of health care. The ethos during consultations was to value and respect other forms of treatment chosen by individuals taking part in the study. The Code of Ethics for the Society of Homeopaths states that homeopaths must not advise patients to discontinue other treatments and this was strictly adhered to in all consultations during this study. However, many of the participants used comparisons with other treatment experiences to highlight what had been valuable to them in the homeopathic process. Commentary about the experience of homeopathic treatment was frequently expressed in comparative terms, making reference to experiences of conventional health care and placing value on aspects of homeopathic treatment which were not seen as part of conventional health care.

- “When you go to the hospital you see the doctor and it’s a different doctor each time...it’s quite soul destroying” (P6 L30)
- “I think of conventional which always did the trick... but then you were left with something else” (P19 L39)
- “the experience was very different from allopathic medicine” (P9 L33)

Participants highlighted the consistency of care in their experience of homeopathic treatment, the relaxing venue and the sense of being cared for.

### 3.3.5 Summary of selected outcomes from participant interviews

In order to build a summary view of outcomes for each research method used, the following table is repeated at the end of each section. For this section, single quotes from the interviews are provided for each participant. Participants were not asked to summarise their response to homeopathic treatment but the selected quotes below are indicative of their responses generally when describing their experience of homeopathic treatment, either because they were repeated or highlighted by the participant.

**Table 4: P1-10, summary of selected outcomes from participant interviews**

	<b>Participant interviews</b>	<b>Participant case notes</b>	<b>Homeopath's perspective</b>	<b>MYMOP (better &gt; or worse &lt;)</b>	<b>SF-36 PCS</b>	<b>SF-36 MCS</b>
1	"definitely made me much calmer, I'm not so anxious" (L 73)					
2	"I wasn't allowed to take a remedy" (L 30)					
3	"I coped better" (L 51)					
4	"It really worked for me almost right away" (L 38 )					
5	"overall I've made definite progress" (L 48)					
6	"the first remedy it was good, it had a positive effect on the house" (L 49-50)					
7	"incredible, what an improvement" (L 55)					
8	"took away my headaches" (L 41)					
9	"back to a greater sense of commitment to life" (L 63)					
10	"my back is a huge lot better" (L 48)					

**Table 5: P11-20, summary of selected outcomes from participant interviews**

	<b>Participant interviews</b>	<b>Participant case notes</b>	<b>Homeopath's perspective</b>	<b>MYMOP (better &gt; or worse &lt;)</b>	<b>SF-36 PCS</b>	<b>SF-36 MCS</b>
11	"I'm more on an even keel now" (L 40)					
12	"Fascinating" (L 41)					
13	"arthritis was my thing in my wrists ...and it's certainly easier" (L 48-49)					
14	"the general feeling of goodness and feeling well" (L 62)					
15	"I would like to have been able to report bigger changes" (L 125)					
16	"I have responded positively to the treatment" (L 57)					
17	"helped me to cope better" (L 38 )					
18	"there's a healing taking place and it's fairly holistic" (L 38)					
19	"the positive effects came into force more gradually" (L 38)					
20	"a wonderful sensation, something is working" (L 55)					

### 3.4 CASE NOTES OF PARTICIPANTS

The participant case notes provide an opportunity to:

- ❑ identify symptoms experienced by participants and trace changes over the treatment period
- ❑ gain greater understanding of the life experiences of participants in this study and how these life experiences impact on health and well being
- ❑ trace any changes that occurred during the research period which may have been related to homeopathic treatment
- ❑ identify any themes in the homeopathic experience that were common to several participants in the study

By paraphrasing and anonymising participants' case notes it has been possible to explore the narrative account of their experience of illness and their response to homeopathic treatment. The case notes include information about symptoms they wished to resolve, past health history, family health history, life experiences, life style and a summary of all declared symptoms at the time of treatment. This is a rich source of information about individuals in the study and a source for confirming information from other measures used to assess the value of homeopathic treatment. However all information is confidential and participants were assured of this in the patient information leaflet that was sent to them before starting treatment. This was also confirmed by the Research Ethics Committee at Queen Margaret University as part of the ethics approval process. The information provided to participants taking part in this study stated:

“All the information that you give will be confidential and it will not be possible for you to be identified in any reporting of the data gathered.” (Patient Information 2007)

Although participants signed an agreement to take part in the research and for information about them to be generalised for use in reporting on the study, they have the



right of all homeopathic patients to confidentiality. The evidence provided here from their case notes takes account of this.

The role of the homeopath is to listen to individual participant accounts of health and life experiences. Although this may seem similar to narrative accounts collected by researchers, the purpose is not to record narrative for research purposes, but rather to identify a homeopathic remedy which suits the needs of the individual. In this study, textual analysis of the participants' case notes was used to address the research questions on the outcome of homeopathic treatment for this age group, and the common themes revealed by participants about homeopathic treatment. Details of the process used to review the case notes are provided in section 2.4.1.2. *Case notes of participants.*

Analysis of the case notes focuses on:

- ☐ the homeopathic analysis of each case and remedy choice
- ☐ remedy reactions
- ☐ factual information about symptoms and treatment
- ☐ the context in which participants experienced ill health
- ☐ patient beliefs about changes in their health and well being and their experience of homeopathic treatment

### **3.4.1 The homeopathic analysis of participant case notes**

The five main areas covered in the first consultation were:

- ☐ current symptoms which participants hoped would be treated with homeopathy
- ☐ health history and any trends in the history of their family's health
- ☐ life style issues such as eating, sleeping and exercise, focusing on what appeared to be out of balance, rather than choices related to healthy living
- ☐ personality and how participants responded to stressful situations
- ☐ a review of symptoms experienced in different parts of the body working from head to feet

Participants were encouraged to give an account of their symptoms in their own words and this was recorded almost verbatim. The list above was not a prescriptive agenda and participants talked about their experiences without interruption. Questions were only introduced when participants offered no further information. The follow up consultation used the same approach as the first consultation but focused on individual responses to the prescribed remedy and any changes that had taken place in health or well being.

The text of each consultation was used to identify key symptoms or rubrics for analysis using the computer programme CARA (see example of computer analysis in Appendix 2). Remedies for each participant were selected by matching their key symptoms, personality traits and history with the remedy pictures outlined in homeopathic *Materia Medica* such as Morrison (2005) and Tyler (second edition 1952). Follow up consultations were used to record remedy reactions and any additional health or life experiences which the participants chose to describe. If the first remedy did not stimulate a healing reaction, a different remedy was prescribed. If there was an improvement in health or well being, the same remedy was repeated. If there was an improvement and then a return of some symptoms it was usual to repeat the same remedy but at a higher potency ie LM 2 instead of LM1. A summary of all remedies prescribed is provided in Appendix 11.

Case notes revealed that there had been important changes for many participants which they felt were attributable to the homeopathic remedy and/or treatment process. These changes are confirmed in participants' responses to interview questions. Participants also referred to their experience of homeopathic treatment. The words they used to describe their state of health and well being at the end of the study are paraphrased below. These are not attributed to specific participants and reflect the notes taken during the consultation by the homeopath/researcher. Although these notes were taken almost verbatim, it was important to maintain non-verbal contact with participants and therefore it was not always possible to record everything that was said. Each bullet point reflects notes made at a specific consultation with an individual participant. The notes are

grouped into categories to show the type of comment that was made about the homeopathic experience.

- ❑ Change in experience of pain, discomfort or improved mobility:
  - Back has remained tons better
  - Reduced use of steroid inhaler for asthma, no use of blue inhaler, no pain in her hip or elbow
  - Joint pain seems better, wrists not sore
  - Overall in the last three months has experienced 75% improvement in joint pain and mobility
  - Second remedy hit the spot, less stiff fairly immediately, feels creative
  - Able to dance and lift things without pain, energy to do things, after second remedy pain was excruciating then had bout of sneezing and pain disappeared, also bout of feeling down then felt as if cloud lifted

These comments suggest that there has been noticeable improvement in physical symptoms since starting homeopathic treatment. Participants commented on the reduction in pain, increased mobility and ability to do things that were not possible before treatment. One participant referred specifically to reduced use of medication. Although these comments highlight physical improvement, there is also the suggestion that mood improved too. The following comments refer more specifically to changes in emotional well being.

- ❑ Change in perception of well being, energy and enjoyment of life:
  - Definitely better as a result of taking the remedy, little things are not stressing her, no 'niggly' arguments with husband, not worrying needlessly, rarely angry, easy going at work
  - Pretty good, upbeat and cheerful, excited about future
  - Cheerful with things to do

- E-mail saying he had been quite well since final appointment
- Grateful for improved energy, ability to do things that were beyond her before taking remedy, feels joyful, calm about things that normally upset her, can run up and downstairs
- Felt detached, intolerant of others, now feels life is good
- Sense of being herself again, a bit like wading through mud and getting onto dry land
- Feels as good as she's been in ages
- Levels of peacefulness, happiness and energy are consistently up
- Feeling better, more positive, enjoying life, aware of how much better she is since starting the remedy
- Feels so well in comparison to a few months ago, writing in diary has shown progress, more joyful, more laughter

These comments indicate perceived improvement but also the nature of the improvement. For some participants feeling better meant an improvement in relationships and tolerance for others. For some the feeling is of increased enjoyment of life. Several participants made direct comparisons with how they felt in the past, either stating that they felt much better than before or that they felt like they used to in the past before their symptoms became a problem.

Not all participants experienced positive changes as a result of taking the homeopathic remedy and the treatment process. There was no evidence of deterioration in symptoms associated with homeopathic treatment but expressions of disappointment that hoped for improvement did not occur. In some cases, a different remedy produced an improvement or there was a positive change over time.

- ❑ No evidence of change as a result of homeopathic treatment initially:
  - Felt optimistic about remedy but it didn't do anything
  - Remedy prescribed by doctor with good effect, repeated but no effect, despite positive expectations. After different remedy felt it took the edge off things. E-mail at end of study to say that she had been feeling a lot better.
  - Felt very positive about third remedy prescribed but no reaction, but with fourth remedy symptoms returned when she forgot to take it on holiday

In all the cases mentioned here, the participants had high hopes that the remedy would improve their health. It is not possible to draw any conclusions from this small number of comments, but it is interesting that their beliefs or expectations had no effect on the outcome of treatment. In one case this was particularly noteworthy as she had been prescribed the same remedy before by her GP and had had a positive outcome. These comments also highlight the issue of timescale for recovery as a result of homeopathic treatment. In a research study with a specific timescale and intervals between appointments it is more difficult to follow any ongoing progress. In two cases referred to here, participants felt better after the study was finished and chose to make this known by e-mail.

These reactions to the homeopathic remedy/treatment process indicate positive experiences for 18 participants. One participant experienced no clear improvement and one participant did not take the homeopathic remedy and attributed some improvement in her health to anti-depressant medication. Apart from these two cases, there is a strong indication that positive change took place for the participants in the study. This is supported by their responses to interview questions.

### 3.4.2 Remedy reactions

Typical reactions to homeopathic remedies are described in section *1.3.3 Theory and philosophy of homeopathy*. These reactions may be regarded as evidence of the action of the homeopathic remedy and/or treatment process. Common remedy reactions experienced by participants in this study are recorded in the following table. The specific response to the remedy is recorded in the left hand column. The way that participants described their response is summarised in the middle column and the number of participants (P) who experienced particular reactions is given in the right hand column.

**Table 6: Response to homeopathic remedy**

<b>Response to remedy:</b>	<b>Described as:</b>	<b>P</b>
Short lived aggravation associated with taking remedy	Flu like symptoms, sneezing, spots on face, felt agitated, rash, thirsty, taste of salt, sore eye, 'plukes', runny nose, worst cold ever, piles worse	8
Improvement in quality of sleep	Better, slept well, didn't wake in the night	8
Improvement in energy levels and motivation	Interested in work, felt like myself again, baked a cake, better concentration, felt resilient at work, cleared out house clutter	10
Improvement in physical symptoms	Pain in joints better, able to move easily, asthma improved, constipation better, eyes clear, less headaches, skin condition better, back pain better, sinusitis loosening up/catarrh, needed less medication, less diarrhoea, hot flushes diminished	13
Improvement in emotional symptom	Calmer, cheerful and positive, busy, joyful, joking, better at making decisions, focused at home and work, improved relationships, peacefulness, dealing with issues in more relaxed way, return to activities which give pleasure, bad memories no longer a problem	10

Although homeopathy is treated as a complex intervention in this study, taking account of the effect of the remedy, the therapeutic relationship and the use of self care methods, in this section the focus is specifically on remedy reaction. Table 6 shows how participants described their experience of taking the remedy.

Most participants described improvement in main symptoms and well being, with the following exceptions:

- ❑ in one case no remedy was prescribed
- ❑ one participant experienced no improvement
- ❑ one participant experienced improvement in one symptom, and acknowledged possible benefit from treatment when symptoms returned after stopping the remedy
- ❑ one participant described limited benefit from one remedy, but e-mailed after the study to report that she was feeling much better

Some reactions to the homeopathic experience and the use of homeopathic remedies were surprising to participants. These reactions reflect the description of homeopathic theory and philosophy in section 1.3.3.

The following table summarises surprising remedy reactions as described by participants and recorded as accurately as possible by the homeopath/researcher. The significance of these reactions is that they were not expected by participants and therefore unlikely to be related to participant expectations about treatment. They are also linked to common responses to homeopathic remedies. They provide evidence that participants believed something happened as a result of taking the homeopathic remedy. These comments from case notes are confirmed in the participants' responses to interview questions.

**Table 7: Surprising reactions to homeopathic remedy identified by participants**

<b>Reaction:</b>	<b>Description:</b>	<b>Experienced by:</b>
Talking about issues from the past or which were deeply personal	‘like going to the confessional’, surprised to be talking about the loss of a child 30 years ago, about childhood hurts, about past relationship	12 participants
Crying during the consultation or afterwards	Crying when remembering past losses, particularly parents or mother	4 participants, other participants cried in consultations but regarded this as unsurprising
Positive change in mood, feeling joyful	Singing in the bathroom, giggling, feeling joy, peace, calm, relaxed	3 participants referred to feeling joyful, 7 participants referred to improved mood
Short lived physical symptoms after taking the remedy	Spots, rash, sneezing, return of old symptoms, bad cold, flu like symptoms, agitation, taste of salt, lost voice	8 participants
Improvement in physical symptoms not mentioned in consultation	Pain in elbow, brown liver spots reduced on hands	2 participants
Surprising improvement in physical symptom	No longer constipated on holiday, bloodshot eyes cleared, hair curling, sense of healing crisis, sneezing for half an hour and pain disappearing, stirring of sexual desire	6 participants
Expectation that remedy would produce reaction and nothing happened	Prescribed by doctor before, looked it up on internet and felt it was right, believed in description of remedy picture given by homeopath	3 participants



### 3.4.3 Patient beliefs about homeopathy and changes in their health

Perceptions of changes in health and well being that occur as a result of specific treatment may result from beliefs held by individuals about the efficacy of the treatment. (See section 1.2.2 *Beliefs about health, illness and ageing* for literature on the impact of beliefs on health and healing) In order to evaluate the outcome of homeopathic treatment, it seemed important to assess the influence of prior knowledge and expectations of homeopathic treatment and measure this against the outcomes of treatment.

Participants were asked about their knowledge of homeopathy at the beginning of the first consultation and gave the following paraphrased responses:

- No knowledge of homeopathy
- Use of homeopathy suggested by a friend with experience of homeopathy
- Homeopathy was a last resort having tried everything else
- Felt that they might as well give it a try
- Thought it (homeopathy) was something else eg osteopathy, herbal medicine
- Previous use of homeopathic remedies
- Belief in holistic therapies and use of other complementary therapies

This shows a range of attitudes to homeopathy at the beginning of the treatment process, but in the participants' descriptions of outcomes of treatment there was no evidence of a similar range of attitudes. In the case notes participants did not make a connection between the outcome of treatment and their beliefs. In individual interviews, participants were asked to give more information about their beliefs about health and healing, and their perception of the effect of homeopathic treatment. Their responses to these questions confirm that there appears to be no strong connection between participants' belief in homeopathy and positive outcomes of treatment in this study.

### **3.4.4 Participants' symptoms and treatment**

The 20 participants in the study presented with a range of symptoms. Although symptoms have been classified as physical and emotional, there were strong connections between them, for example, inability to sleep, or digestive problems associated with anxiety. There were also strong connections between the narrative of the participant and the experience of ill health, for example, stress at work linked to anxiety.

Information about their physical symptoms is presented first because in most cases participants stated that this was what they wished to be treated. The physical symptoms described also provide a way of measuring improvement over time by comparing initial symptoms with evidence of symptoms at the end of the study.

#### **3.4.4.1 Physical symptoms**

Participants presented with a range of physical symptoms, some associated with ageing and others common conditions which they had experienced for many years. These symptoms are summarised in the table below. The symptoms are described in general terms first, then more specifically using the type of language used by participants to describe the way they experienced these physical symptoms. The number of participants who reported any symptom is provided and also their expectation about what they wished to be treated or what they believed could be treated.

The physical symptoms are grouped under 11 main headings in the following table, with those symptoms experienced by most participants listed first. Joint pain for example, was experienced by 14 participants. Of the 14 who reported joint pain, nine had reported it as a symptom they wished to be treated. In contrast, lack of energy, reported by 10 participants was a symptom that all 10 participants hoped would improve as a result of treatment.

**Table 8: Summary of participants' physical symptoms**

<b>Symptom:</b>	<b>Experienced by:</b>	<b>Type/description:</b>	<b>Expectation of treatment:</b>
Joint pain, back pain	14 participants for periods of between 18 months and 25 years, also intermittently	Stiffness on rising, pain in shoulder, arm, wrist, fingers, hips, knees, feet, gout	Treatment symptom for 9 participants
Lack of energy, inability to do things easily	10 participants, both short term tiredness and chronic fatigue	Lack of motivation, feeling unable to cope/tackle tasks	Treatment symptom for all
Digestive problems	7 participants, mostly long term symptom	Constipation, piles, acid reflux, IBS, gastritis, flatulence	Treatment symptom for all
Skin problems	6 participants, acute, intermittent or long term condition	Shingles, eczema, vitiligo, athlete's foot, skin tags, hot flushes	Treatment symptom for 5 participants
Headaches and/or sinusitis	5 participants, long term symptom, up to 40 years	Migraine, headache, sinusitis, pain, difficult to breathe and concentrate	Treatment symptom for all
Sleep problems	5 participants	Associated with anxiety and/or pain	Treatment symptom for all
Breathing problems, asthma	4 participants, 2 recent symptom, 2 long term symptom	Asthma, short of breath, cough, allergy, sleep apnoea	Treatment symptom for 3 participants
Diabetes	3 participants	Type 2 diabetes	No expectation of treatment effect
Hypertension	2 participants		Treatment symptom for 1 participant
Thyroid deficiency	2 participants		No expectation of treatment effect
Loss of physical sensation eg smell	1 participant, initially 13 years ago, then 1 year ago		No expectation of treatment effect

The physical symptoms summarised in Table 8 provide a measurable way of assessing the outcomes of homeopathic treatment. Participants were able to quantify improved sleep, for example, or identify ways in which they were more mobile as they experienced less physical pain. This is an important identifier of the value of homeopathic treatment for this group of participants.

Some of the physical symptoms were closely associated with emotional symptoms and these are summarised below. The division of symptoms into physical and emotional is in some ways artificial, but it may be helpful in attempting to assess changes in health and well being.

#### **3.4.4.2 Emotional symptoms**

Emotional symptoms can be difficult to describe and quantify. In many cases the awareness of emotional symptoms comes through a physical experience such as a panic attack or extreme tiredness. Homeopathic patients often focus on physical symptoms in describing what they feel is wrong and use the change in physical symptoms as a measure of improvement. For this reason, physical symptoms have been presented first in this section, but in terms of the importance of symptom relief to individuals it was often the emotional symptoms that caused participants the most distress.

The emotional symptoms listed below were described by participants as emotions which prevented them from living their lives in the way they would choose to live normally. These symptoms were associated with experiences in the recent past and also in the more distant past, in some cases several decades ago.

The symptoms have been grouped under four main headings with the number of participants who experienced this symptom. The description of the emotional symptom given by participants is included and their expectation about the possibility of treatment. The most common experience reported by 11 participants was anxiety and this was a

treatment symptom for all. Anger or irritability was reported by eight participants but none of them had any expectation that this would be relieved by homeopathic treatment. The participants' accounts of negative emotional states are important when assessing outcomes of homeopathic treatment. By the end of the study, many participants described an improvement in mood and well being which compares with negative accounts of emotional symptoms at the first consultation.

**Table 9: Summary of participants' emotional symptoms**

<b>Symptom:</b>	<b>Experienced by:</b>	<b>Described as:</b>	<b>Expectation of treatment:</b>
Anxiety, stress	11 participants	'nervous tummy', anxiety about health, 'neck pain caused by stress', 'falling apart', worried, 'can't cope', 'everything is down to me', 'overwhelmed', stressful job, bullying, worries about money, the future 'what if'	Treatment symptom for all
Depression, sad, lack of motivation, cries easily, loss of pleasure, alone, disconnected, overwhelmed	10 participants	'life is pointless', 'sadness', 'doom, gloom and lethargy', 'not the same person', 'winter blues', 'feeling low', cries easily, 'sad about life', dwelling on past, 'clock that's wound down', 'full of secrets', 'feels abandoned'	Treatment symptom for all
Anger, irritability	8 participants	Irritable, impatient, house has to be immaculate, 'snippy', 'nippy', annoyed about traffic, judgemental, needs control, anger, resentful	No expectation of treatment effect

The common theme in the description of emotional symptoms is the inability to live life normally because of the feelings being experienced. There was evidence of lack of motivation and lack of energy to face challenges. There was also a sense of being overwhelmed by what was happening to them. They described different emotional reactions but the common theme was that these emotions were strongly felt and difficult to ignore. This evidence of emotional symptoms provides a way of measuring improvement by noting any change in mood over time.

An additional measure of improvement in emotional symptoms may be an improvement in related physical symptoms such as digestive problems and pain. It is also likely that an improvement in physical symptoms such as pain will lead to an improvement in mood. Additionally, the limitations experienced by people who are unwell can be removed when their health improves and this may lead to an improvement in emotional well being as they resume their social life and take pleasure in former pursuits.

The aspect of improvement in emotional well being which is most difficult to quantify is improvement in relationships with others. Some participants who felt their health had improved also reported an improvement in the way they related to others. There is limited evidence of how others experienced this change in mood. In the interviews, one participant referred to “a positive effect on the house” which suggests that the change in emotional well being was noticed by others.

These emotional symptoms described by participants were expressed in terms of current experience. The prescription of a homeopathic remedy is based on analysis of all aspects of the individual’s account of health and life experiences. This includes past trauma or suppressed emotions from past experiences. Participants were asked to identify the time that symptoms began and anything different that was happening in their lives at that time. This is defined as an ‘exciting cause’ of symptoms. In one case, the participant identified a major operation as the time when symptoms began. In another case, a difficult relationship experienced decades earlier was perceived to be the cause of symptoms.

For some participants their emotional symptoms were attributed to ongoing situations at work or home, or related to their physical health problems. Continued stress because a situation is unresolved is referred to in homeopathic treatment as a ‘maintaining cause’. It was common in the early days of homeopathy for maintaining causes to be related to physical issues such as poor housing, so that patients with bronchitis would improve with homeopathic treatment but the condition would recur because of damp living conditions. Nowadays, it is more common to see individuals who are ‘stuck’ in some way because of their feelings about past or present experiences. If individuals feel better emotionally as a result of homeopathic treatment, they may be able to handle difficult situations more easily. Several participants in this study reported this and it is therefore worthy of further consideration as evidence of the effect of homeopathic treatment.

Table 10 summarises exciting and maintaining causes which were identified by participants in this study. Some participants had experienced more than one of these causes. Participants were not asked to identify causes but did so spontaneously as they described past experiences. They also made the connections themselves between the symptoms they were experiencing and past trauma and/or current stress.

By recording the participants’ view of these causes it is possible to make connections between their state before treatment and any change after treatment. Changes in behaviour in specific situations or changes in feelings about the cause of their distress provided an additional measure of the effect of homeopathic treatment. For example, some participants reported that they no longer felt angry about past issues or felt more able to manage difficult situations without becoming upset.

**Table 10: Exciting and maintaining causes of emotional symptoms**

<b>Exciting cause:</b>	<b>Associated with symptoms of:</b>	<b>Maintaining cause:</b>
Past illness, surgery or medical treatment	Asthma, depression, joint pains, sleep problems, pain	Ongoing use of medication
Break up of marriage	Anger, depression, pain	Unresolved emotions
Stress at work, bullying	Depression, tiredness, skin problems,	Continued stress and demanding workload and/or difficult relationships
Over responsible, strict upbringing	Low energy	Tendency to take on too much and become overwhelmed, perfectionist
Bereavement	Depression	Ongoing grief, loss
Anger	Pain, loss of energy, hot flushes	Ongoing anger about unresolved situation
Loss of child, miscarriage	Sadness	Grief
War	Sadness, vulnerability	Grief, disturbing memories
Difficult relationship	Depression, flashback memories, pain	Ongoing emotions associated with past experiences
Suppressing emotions	Depression, pain	Bottling up feelings, just getting on with life, remaining in initial emotional state

In the homeopathic consultation, participants described both exciting and maintaining causes, indicating that they made a connection between their current state and their past experiences. The importance of this to homeopathic treatment was not referred to by participants, but it was clear that most of them believed that their past was an important part of any assessment of their current state of health.



### **3.4.4.3 Acute illnesses and trauma experienced by participants**

Acute illness or trauma experienced by participants in any research study may have an effect on the outcome of the study. In the 55+ age group it is perhaps even more likely that there will be additional health and life experiences which have an impact on the well being of participants. In this study, some participants did experience both acute illness and significant trauma.

Four participants experienced acute dental problems during the study and were treated with antibiotics and surgery. Their homeopathic treatment was disrupted by this, but resumed afterwards. In two cases, homeopathic remedies were prescribed to help participants cope with trauma and the dental condition.

Six participants experienced bereavement during the study. Two participants experienced the loss of their mother and one lost her father-in-law. One participant lost an uncle, another experienced the loss of a young woman who had been a lodger, and another experienced the loss of a close friend of her daughter. Another participant experienced the trauma of anticipating her mother's death. The 55+ age group may be more likely to experience bereavement, or it may be that in this study the information about bereavement was shared in response to questions about recent experiences that had an impact on health and well being.

The homeopathic consultation was an opportunity for participants to share their distress about these experiences. Some participants chose to talk about how they felt about their loss or distress, but others preferred not to discuss their feelings about bereavement. It is particularly difficult to measure progress when individuals are in a distressed state or feel that talking about their feelings would be too difficult. In some cases, participants were able to say that given the circumstances they were doing well and perhaps better than they would have been without homeopathic treatment. In one case, the participant felt

that having someone to talk to had been very important in helping her to cope with trauma.

Reviewing the case notes makes it possible to take account of these life events when considering the impact of homeopathic treatment. It is also possible to make comparisons with results in the quantitative data and note if the responses to more objective questions about well being reflect the same change as the case notes at a difficult time for particular individuals.

#### **3.4.4.4 Use of pharmaceutical medicines**

The 55+ age group commonly use prescribed medicines to treat symptoms relating to ageing and ill health. At the initial consultation, the participants in this study were asked to provide information about the use of prescribed medicines. This information is important when taking a homeopathic case for the following reasons:

- ❑ Some medicines produce side effects which might be mistaken for symptoms to be treated.
- ❑ It is also possible that improvement results from medication and not from the homeopathic treatment. In this study, all participants were established users of these medicines before starting homeopathic treatment and reported ongoing symptoms despite taking the prescribed medicines.
- ❑ In some cases, the medicines had produced some improvement but not sufficient to make the individual feel well.
- ❑ In other cases the medicine produced unwanted side effects or the individual disliked taking the medicine.

The medicines listed below give an indication of the range of medicines used by participants in this study. For some participants discontinuing the use of pharmaceutical medicines was not a safe choice for them to make, but for others homeopathic remedies offered a less aggressive form of treatment for common ailments.

Of the 20 participants in this study, six used no pharmaceutical medicines. One participant self prescribed Aspirin but did not explain why he chose to do this. In one case, improvement in health was attributed to reducing the use of painkillers as well as the homeopathic remedy.

The participants in this study were asked to complete a questionnaire at the first appointment which gave personal details but also recorded any medicines that they were taking. 14 participants stated that they were taking one or more of the following medicines, but were not asked to provide information about why the medicine was prescribed:

Actos pioglitazone, Aspirin, Atenolol, Benadryl, Bricanyl, Cipralex, Colpermin, Diamocophanol, Diclofenac, Dyhydrocodeine, Estradiol, Fentanyl patches, Flixonase, Frusemide, Lansoprazol, Lisinopril, Levothyroxine, Metformin, Mirtazapine, Salmeterol, Simvastatin, Thyroxine, Voltarol.

Some participants reported some reduction in the use of medication for some symptoms during the study, for example Diclofenac taken for pain. It was not part of the aim of this study to measure changes in the use of pharmaceutical medicines and reports of changes in the use of medicine were given spontaneously by participants as part of their account of the state of their health. The MYMOP questionnaire did ask about use of medication and responses to the questions on medication are presented in section 3.6.2 *Summary of responses to MYMOP questionnaire*.

#### **3.4.4.5 Use of other complementary therapies**

The use of other complementary therapies was also considered in order to note any beneficial effects on participants' symptoms, or any effect on homeopathic treatment. (For example, it is believed that aromatherapy oils can antidote the homeopathic remedy.) In all cases, the use of other CAM therapies was established before starting homeopathic treatment. In one case, treatment from a chiropractor was credited with resolving pain in a shoulder joint during this study. In most cases the use of other therapies was regarded

as an additional support with a different purpose from homeopathic treatment and potentially different outcomes for the user.

Ten participants used other complementary therapies, either for specific conditions or on a regular basis to improve well being. Therapies used included:

acupuncture, chiropractic treatment, counselling, cranio-sacral manipulation, kinesiology, massage, psychotherapy, reflexology, Tai chi, yoga

Some participants using these therapies were also practitioners in the chosen discipline. They spoke of their belief in the therapy for the chosen purpose, such as increased suppleness or relaxation, but did not see the therapy as curative.

#### **3.4.4.6 Use of self care methods to improve well being**

For the purposes of this study, homeopathic treatment has been defined as a complex intervention, including the homeopathic remedy, the therapeutic relationship and self care. Self care was defined as an individual's chosen methods of improving health and well being, based on their expressed beliefs about the value of specific life style choices rather than well researched methods of improving health.

Participants were given some advice on self care in the leaflet explaining how to take the homeopathic remedy. This was included with every prescription of their particular remedy. In consultations, they were asked about diet and exercise as a way of finding out what foods appealed to them and how much energy they had, both indicators for prescribing homeopathic remedies. This often prompted discussion of methods used by participants to take care of themselves. This may have provided an opportunity for the individuals to recommit to particular self care strategies.

The following self care strategies were identified by individuals in the study:

- ❑ three participants used discussion with a supervisor as part of their employment as a way of off loading worries
- ❑ one participant used the Samaritans and a community psychiatric nurse
- ❑ three participants used prayer as a means of self care
- ❑ two participants referred to the use of specific food supplements eg glucosamine
- ❑ three participants used regular walking to improve their health

Some participant expressed the view that they had a good diet. Other participants referred to self care methods which they believed would benefit them but which they had not implemented or had not taken part in recently.

There was no clear evidence in the case notes that individuals changed their behaviour in relation to self care or that the self care methods they continued to use had any impact on the outcomes of the study. This was supported by responses to interview questions which asked them directly about self care. In both the case notes and the responses to interview questions most participants said that they had not changed their behaviour in terms of self care as a result of taking part in this study.

### 3.4.5 Summary of outcomes including participant case notes

The following table is repeated at the end of each section to allow comparisons between research evidence for each participant for each research method. For this section a summary from the case notes taken by the homeopath/researcher for the final appointment is used. This is a summary of the participants' expressed beliefs about outcomes of homeopathic treatment.

**Table 11: P1-10, summary of selected outcomes from participant case notes**

	<b>Participant interviews</b>	<b>Participant case notes</b>	<b>Homeopath's perspective</b>	<b>MYMOP (better &gt; or worse &lt;)</b>	<b>SF-36 PCS</b>	<b>SF-36 MCS</b>
1	"definitely made me much calmer, I'm not so anxious" (L 73)	Better physically and emotionally				
2	"I wasn't allowed to take a remedy" (L 30)	Improving using anti depressants and self care				
3	"I coped better" (L 51)	Better physically and emotionally				
4	"It really worked for me almost right away" (L 38)	Better physically				
5	"overall I've made definite progress" (L 48)	Better emotionally				
6	"the first remedy it was good, it had a positive effect in the house" (L 50)	Improvement in mood, sleep, energy				
7	"incredible, what an improvement" (L 55)	Better physically and emotionally				
8	"took away my headaches" (L 41)	Improvement in headaches on first remedy				
9	"back to a greater sense of commitment to life" (L 63)	Better physically and emotionally				
10	"my back is a huge lot better" (L 48)	Better physically				

**Table 12: P11-20, summary of selected outcomes from participant case notes**

	<b>Participant interviews</b>	<b>Participant case notes</b>	<b>Homeopath's perspective</b>	<b>MYMOP (better &gt; or worse &lt;)</b>	<b>SF-36 PCS</b>	<b>SF-36 MCS</b>
11	"I'm more on an even keel now" (L 40)	Some improvement				
12	"Fascinating" (L 41)	Better physically and emotionally				
13	"arthritis was my thing in my wrists ....and it's certainly easier" (L 48-49)	Improvement in sleep and joint pain				
14	"the general feeling of goodness and feeling well" (L 62)	Better emotionally, main physical symptom improved but not resolved				
15	"I would like to have been able to report bigger changes" (L 125)	No change				
16	"I have responded positively to the treatment" (L 57)	Better physically and emotionally				
17	"helped me to cope better" (L 38 )	Better emotionally				
18	"there's a healing taking place and it's fairly holistic" (L 38)	Better physically and emotionally				
19	"the positive effects came into force more gradually" (L 38)	Better physically and emotionally				
20	"a wonderful sensation, something is working" (L 55)	Better physically and emotionally				

### 3.5 PRACTITIONER REFLECTIONS

The use of practitioner reflections in qualitative research provides an additional perspective on the process and outcomes of the study and can support the validity of information gathered from other sources. In this study, the homeopath was also the researcher and although this dual role is more common in modern qualitative research it does carry the risk of bias and subjective interpretation of experiences and evidence.

The purpose of reviewing the reflective journal is to:

- ❑ review the process and outcomes of treatment by considering the research questions from the perspective of the practitioner
- ❑ review the role of the homeopath and researcher and any challenges or conflicts resulting from the dual role
- ❑ consider the impact of any other issues on the ability to manage either role professionally and in the best interests of the participants

Reflective notes were made after each of the four consultations with research participants. The notes for each participant were grouped together, but no other order or length of entry was prescribed. Notes were also made if significant contact was made with participants between appointments, or if some issue arose which was relevant and important to the research and the researcher. The purpose of the notes was to record observations about the experience of providing homeopathic treatment. Additionally, the reflective journal was a resource for questioning assumptions and beliefs held by the homeopath/researcher and any emotional responses experienced as a result of interaction with participants. The notes were not reviewed during the research and not amended after the research was completed.

Summaries of entries in the reflective journal are provided below but not attributed to individual cases. The analysis of the reflective notes was carried out in the same way as



the analysis of case notes of participants. The notes were reviewed and significant commentary about the experience of providing homeopathic treatment was highlighted. The highlighted sections were then grouped thematically in a table, identifying participants by number and appointment. Relevant quotes from the reflective notes were listed under thematic headings.

The reflective notes were analysed under the following thematic headings:

- ❑ the outcomes of treatment
- ❑ the process of treatment
- ❑ the role of caring professional
- ❑ the role of independent researcher

### **3.5.1 The outcomes of treatment**

The purpose of the reflective journal was not to record outcomes but to reflect on the experience of treating participants. The reflective notes do however contain three types of comment on treatment outcomes: satisfaction about a good outcome, concern about an ambiguous outcome or partial recovery, and disappointment about lack of improvement.

Satisfaction about a positive outcome of treatment was expressed both factually and subjectively, including references to the participant's experience and commentary on that experience. Extracts from the reflective journal are paraphrased below. Comments are not attributed to specific participants and reflect the notes made after the consultation by the homeopath/researcher. Each item listed below relates to a specific participant's experience. The comments are grouped according to common issues raised, beginning with references to positive accounts of the homeopathic experience. These positive comments were included in the reflective journal as a measure of progress but also as part of the questioning process to assess what had really happened for the individual. In each paraphrase from the notes included below, there is some reference to homeopathic

markers of progress which helped to confirm the relevance of what participants said in homeopathic consultations.

- It was noted that a participant had commented on key indicators of homeopathic success without being prompted to do so ie more energy, less anxiety, calmer, better relationship with others, as well as improvement in physical symptoms.
- An account of improvement in health and well being was provided by one participant who was very articulate and able to describe her impression of the homeopathic experience very exactly, using phrases like ‘feeling herself again’ and talking about the joyfulness coming back into her life.
- Satisfaction was expressed when an appointment was very straightforward with evidence of sustained improvement in a key symptom and general improvement in well being.
- The use of language by participants was an important guide to their response to the treatment, for example one participant used the word ‘definitely’ when he described the more peaceful state he had experienced since taking the remedy. He was observed to be more open and seemed genuinely more relaxed about time than before.
- The impact of additional trauma on participants was noted, for example one participant seemed much better despite her mother being very ill and the possibility of losing her soon. She was warm in her praise of the homeopathic experience.
- Changes in the presentation of individuals and their preoccupations during the consultation were also noted as a measure of improvement or change. In one case it was noted that the participant didn’t cry during the consultation as she had done before and was keen to talk about her work. Most of the problematic issues talked about in previous consultations did not seem important any longer.

Some participants were less definite about improvement. The reflective journal includes commentary on their responses to treatment and possible reasons for the outcome:

- In one case the participant reported some improvement in asthma and ability to run without using an inhaler but she still described a great deal of anxiety. This suggested the need to try another remedy.

- One participant was better but the improvement did not continue. It was noted that it is almost more frustrating when patients experience benefit from homeopathy and then it stops, than not getting the right remedy at all.
- The behaviour of participants sometimes made it difficult to get information that would lead to the correct remedy choice. One participant, for example, wanted to focus on physical symptoms and was cautious about describing improvement, whereas his wife who attended with him was keen to point out the significant changes which had taken place, particularly in mood and energy.
- In one case it was difficult to assess what was a symptom and what was her choice of the way to live her life. This led to reflections on whether a homeopath can make too much of the change in mood – the ontological change – people come to a consultation with a pain and if the pain is gone is there a need to focus on the way they view their life?
- Some participants seemed more likely to be dismissive of homeopathy because of their background and their expressed views about homeopathy. It was surprising when one such participant noted clear improvement in joint pain after taking the homeopathic remedy.
- In one case there was a very clear statement about improvement but there was also a reluctance to attribute it to homeopathy because the mechanism of homeopathy was not understood by the participant.
- In some cases lack of positive outcomes was attributed to the timing of appointments. If the interval between appointments was too long or too short it was difficult to assess the need to change the remedy. In one case, it suited the participant to come for an appointment three weeks after starting the remedy and although there was evidence of a remedy reaction, it was too early to be sure that this remedy was going to make a significant difference.

For some participants there was no improvement in their general health after prescribing a particular remedy. This was referred to in the reflective journal in terms of disappointment or concern about the approach used.

- One participant was definitely quite flat in her presentation and although one main symptom was better there was no general improvement in well being or energy.
- Although one participant expressed satisfaction with the consultations, a well indicated remedy had not made much difference to her health.
- Lack of progress with one participant was recorded as a concern that a different remedy might have made a difference and the approach of watching and waiting had gone on too long.

- One participant had difficulty talking about herself. It was only after several consultations that she revealed enough to identify the most useful remedy. If she had been a paying patient she may not have continued treatment for this long.

The focus of the commentary in the reflective journal can be seen to be largely about the homeopathic treatment process. It is clear that at this stage in the study the focus was on the role of homeopath rather than researcher and the outcomes of treatment.

### **3.5.2 The process of treatment**

The key themes in the reflective journal about the process of treatment relate to:

- ❑ participants' perceptions of health and illness
- ❑ connections between their presentation in the consultation and the choice of remedy
- ❑ evidence that participants tried, sometimes successfully, to control interaction in the consultation and divert discussion away from issues relating to them

Participants' general perceptions of health and life experiences seemed to be affected by how they felt at the time of the appointment. The following summaries of entries in the reflective journal show that this is evident in the way they behaved towards the homeopath and their interpretation of wellness, which also seems to be affected by long held beliefs about the state of their health. This may be most relevant when treating the 55+ age group, as life and health experiences may determine perceptions of wellness or ill health.

- There was some evidence that participants' perceptions about health and well being were very much in the moment. If they felt well they forgot how they were before and had different expectations about wellness in the future. Their need for a relationship with the homeopath is also different when they are well, as if a sign of wellness is forgetting about homeopathy and the homeopath.

- It was noted that one participant brought flowers as a thank you which can be interpreted as a sign of wellness and a signal of the end of the dependence of illness.
- For one participant it was noted that changes in her view of a stressful situation started about 10 days after beginning the remedy. She had a more positive view of the situation and interpreted the behaviour of others differently.
- One participant said her health was very good but her answers in the SF-36 questionnaire suggested otherwise. This suggested that the perception of the general state of health related to the individual's viewpoint. This raises the issue of whether health and well being is measurable in an objective way through the use of questionnaires such as SF-36.
- Another participant was keen to present herself as well and to rationalise any health problems she had. Her perception of herself was as a well person and she disliked admitting to any other view of her health.

These comments about participants' perceptions of health and well being, the connections they made between life experiences and health, and their relationship with the homeopath, are all important when analysing the impact of beliefs on the healing process. It is possible that the homeopath and individual participants had different beliefs about the meaning of health. Individual participants also had different needs, such as the need for a relationship with a health care practitioner, when they were ill and not when they were well. This led to questioning about the ability of individuals to complete objective questionnaires given these different perspectives. The reflective journal focuses here on the researcher role and considers the benefits and limitations of different research methods. The use of both quantitative and qualitative methods for measuring outcomes of treatment has the potential to provide conflicting as well as complementary information about outcomes of treatment.

The reflective journal provided an opportunity to question both the role of the researcher in choosing research methods and the role of the homeopath in choosing treatment methods. The connection between the choice of remedy and the behavior of the individual in the consultation is referred to in the reflective journal both as a warning to

avoid making assumptions, but also as a factor to be included in the decision making about the remedy to be prescribed.

- One participant was very lively and talked for the whole appointment which was very long. This suggested a specific remedy.
- One participant told a very sad and difficult story but seemed so cheerful and positive. This could have lead to the assumption that the indicated remedy was Staphysagria but there was a need to check this assumption carefully.
- Remedies come to mind depending on the behaviour of patients, for example arriving exactly on time for the consultation could indicate the remedy Nat mur, being very cheerful could be Phosphorus. Assuming these character traits is not helpful for the homeopathic analysis.
- One consultation took less than the usual amount of time and the participant seemed to be guarded in her answers. It was as if she had told her story many times and had selected in a protective way, a method for telling the story which made her seem a bit cold. This was part of the analysis of her case which led to the remedy choice.
- One participant was very positive and rational and there was a feeling that she had everything under control. The GP she had seen had also had this feeling about her. It led to thoughts about remedies for people who apparently cope well and then experience physical or emotional collapse, almost unexpectedly.

However self aware and experienced a practitioner is, there is an element of risk in the interaction with patients. In this study, the information contained in the reflective journals indicates that participants tried, sometimes successfully, to control the dialogue in the consultation and divert discussion away from issues relating to them.

- Regret was expressed about giving into one participant's desire to keep things on a superficial level by laughing and joking and avoiding the real issues.
- One participant would often start discussions about social or political issues, often the kind of discussion that socially would be very enjoyable, but which may have been a way of avoiding talking about herself.
- One participant described herself as secretive and did often turn the conversation to something general or ask questions requiring an opinion which diverted discussion away from her.

These observations about the behaviour and beliefs of participants seem important in terms of both managing their treatment with homeopathy and interpreting their response to treatment. The vulnerability of the practitioner to making assumptions or being manipulated by patients could undermine the ability to prescribe successfully and to achieve positive outcomes from treatment. It is useful to reflect on these issues and to maintain vigilance in order to promote the most useful therapeutic relationship, particularly with participants who repeat certain types of behaviour.

### **3.5.3 The role of caring professional**

The reflective journal provided an opportunity to review the part played by the homeopath/researcher in the treatment process. One key role that was revealed was that of caring professional, showing confidence as a practitioner, empathy for participants but also openness to different, sometimes surprising, possibilities in each case. Reflections on this role reveal something about the process of treatment and the participants' experience but less about outcomes of treatment.

This confidence as a practitioner seemed to come from well rehearsed routines and reflections on past experience as a homeopath.

- The journal refers to the usual routine of preparing for a patient to come for a consultation, the familiarity of this process, the feeling that it is thorough and designed to provide a professional impression, but also to reassure people who have no experience of homeopathy.
- The use of a standard patient form, giving personal details and health history, operations and vaccinations, also medication and past experience of homeopathy if any, was referred to. This has proved an important record in the past, as during the consultation details of medical procedures can be missed out, also names of drugs can be difficult to record if they are unfamiliar. All drugs have to be researched to check for side effects which might be confused with symptoms.
- Reference is made to a consultation that was thorough, calm and well paced.

- This confidence in the manner of the consultation is attributed to reflection in the early years of practice on the manner of the consultation, the use of a home office, appearance and behaviour and the importance of the therapeutic relationship. Reflective practice, discussions with other homeopaths and supervisors have all helped to develop a practice that is believed to be consistent, helpful and professional.

A key aspect of this professional approach is an awareness of the potential for doing harm if patients are not advised to see their GP about symptoms which cause concern.

- In one case it was recommended that the participant see her GP for basic tests for conditions such as anaemia, although there was an unspoken concern that she might have a serious health problem.

The reflective journal provided an opportunity to review feelings about stories told by participants and emotions felt during the consultation. Comments were made about the difference between the presentation of an individual which might have led to the assumption that they were well, and the sadness they said that they were feeling or the difficulty of the story they had to tell. Some participants gave accounts of experiences that were moving and shocking for the listener but the participant showed no emotion. Some participants said that they had never told their story before. They referred to the secrecy and shame that had contributed to the distress of the experience.

Some commentary in the reflective journal indicates surprise on the part of the homeopath about the effect of remedies and confirms comments made by participants in the interviews and case notes. These included stories of rapid and surprising recovery. Some commentary also confirms the participant accounts of the homeopathic experience given in the interview, particularly references to the experience of homeopathic treatment being a 'journey' and the value of sharing experiences during consultations.

In considering the role of caring professional, it is not clear if being a contemporary of participants in the study influenced the outcomes or the process of treatment. It is possible that sharing experiences with participants may have increased the empathy and



openness in consultations and this contributed to the therapeutic relationship. The reflective journal was the only record of this aspect of treatment. It included references to the need to confirm the participant's view of an experience and not make assumptions about how they felt, particularly in relation to shared experiences.

### **3.5.4 The role of independent researcher**

The impact of being the homeopath providing treatment and the researcher studying outcomes and process is an important factor to consider when reviewing this study. Because the researcher was also the practitioner there was a greater risk of bias and a greater need for reflective and honest analysis of the different roles and any conflict of interest involved. The experience of being a researcher and the participants' experience of being involved in a research project were both explored in the reflective journal.

Commentary in the reflective journal valued the experience of being involved in research and highlighted the challenges and the rewards. There was also concern about the number of participants and the work involved in supporting them. Some commentary also suggested anxiety about the research results, for example, caused by scheduling of appointments at a time when the action of the remedy would be most marked. There was an acknowledgement that the nature of homeopathic treatment meant that measuring outcomes had to be secondary to finding the remedy that would lead to better health and well being for participants in the longer term.

Most of the comments in the reflective journal were about issues relating to the participants. There was little questioning of the process used in the consultations or the approach taken by the practitioner. This type of questioning may be a feature of an earlier stage in the career of a homeopath and through reflection, continuing professional development and supervision, an experienced homeopath gains confidence in the process and the management of interaction with patients.

Another limitation of the reflective journal was that there was little questioning of the research process and the role of researcher. This may be explained by the stage in the research when the journal was completed. This was a time when the practical aspects of the study were foremost and the role of homeopath seemed to be more important than the role of researcher. In retrospect this seems to be a lost opportunity to question the dual role of homeopath and researcher and to evaluate the issue of impartiality and the ability to influence participants. It should also be acknowledged that continuing the reflective journal beyond the treatment phase of the study would have been a useful approach. Although the journal was not maintained during the analysis stage of the research process the use of reflective practice through supervision and personal reflections was important in developing the research in the later stages. Critical conversations with supervisors were invaluable in questioning approaches that were familiar to a homeopath, but unfamiliar in research terms.

### **3.5.5 Insights provided by the reflective journal**

In this study, the use of a reflective journal increased awareness of the role of a caring professional, a researcher, and a contemporary of the participants in the study. Additionally, it provided confirmation of results recorded elsewhere in the study and commentary on the process of homeopathic treatment and the common themes in the study. The use of reflective practice is recommended by the Society of Homeopaths as a means of reviewing and analysing the role of homeopath. This promotes openness to new perspectives and different ways of viewing the homeopathic process. The use of a reflective journal can aid the process of seeing each case as different, but also make use of past experiences to promote careful decision making about treatment options.

Reflective practice also provides an opportunity to examine any issues that may cloud judgement or introduce bias. The pragmatic approach to research acknowledges and values different perspectives, including those of the researcher. In this study, there was a need to both acknowledge bias and also retain necessary objectivity to present the views

of participants and analyse data collected. The reflective journal was an aid to this process during the practical part of the research, providing an opportunity for the homeopath to review each consultation. The research process was not included in the reflective journal but was subjected to a similar scrutiny through other reflective activities. These involved:

- ❑ adherence to the research design, which was carefully constructed to avoid bias and provided a reminder of that intention at every stage of implementation
- ❑ frequent and detailed conversations with supervisors at every stage of the research process to evaluate progress and consider the implementation of the research design and avoidance of bias
- ❑ consultation with other professionals to examine the approaches used and rigorously review research methods

The process of reflection underpins all aspects of the practice of homeopathy and is an important aid for all researchers, providing opportunities to review progress and reconnect with fundamental principles of homeopathic practice and research design.

The following table shows a summary of the outcomes of treatment recorded in the reflective journal. This table is repeated at the end of each section to offer a comparison of outcomes as recorded in each research method. For this section, a summary is provided of the homeopath/researcher's view of outcomes recorded in the reflective journal, but based on case notes taken at the final consultation for each participant. In most cases they are the same as the outcomes recorded for participant case notes.

### 3.5.6 Summary of outcomes including homeopath's perspective

**Table 13: P1-10, summary of selected outcomes from the homeopath's perspective**

	<b>Participant interviews</b>	<b>Participant case notes</b>	<b>Homeopath's perspective</b>	<b>MYMOP (better &gt; or worse &lt;)</b>	<b>SF-36 PCS</b>	<b>SF-36 MCS</b>
1	"definitely made me much calmer, I'm not so anxious" (L 73)	Better physically and emotionally	Better physically and emotionally			
2	"I wasn't allowed to take a remedy" (L 30)	Improving using anti depressants and self care	Better emotionally			
3	"I coped better" (L 51)	Better physically and emotionally	Better physically and emotionally			
4	"It really worked for me almost right away" (L 38 )	Better physically	Better physically			
5	"overall I've made definite progress" (L 48)	Better emotionally	Better emotionally			
6	"the first remedy it was good, it had a positive effect in the house" (L 50)	Improvement in mood, sleep, energy	Improving but not better			
7	"incredible, what an improvement" (L 55)	Better physically and emotionally	Better physically and emotionally			
8	"took away my headaches" (L 41)	Improvement in headaches on first remedy.	Improvement in headaches on first remedy.			
9	"back to a greater sense of commitment to life" (L 63)	Better physically and emotionally	Better physically and emotionally			
10	"my back is a huge lot better" (L 48)	Better physically	Better physically			

**Table 14: P11-20, summary of selected outcomes from the homeopath's perspective**

	<b>Participant interviews</b>	<b>Participant case notes</b>	<b>Homeopath's perspective</b>	<b>MYMOP (better &gt; or worse &lt;)</b>	<b>SF-36 PCS</b>	<b>SF-36 MCS</b>
11	"I'm more on an even keel now" (L 40)	Some improvement	Improving			
12	"Fascinating" (L 41)	Better physically and emotionally	Better physically and emotionally			
13	"arthritis was my thing in my wrists ....and it's certainly easier" (L 48-49)	Improvement in sleep and joint pain	Minor improvement			
14	"the general feeling of goodness and feeling well" (L 62)	Better emotionally, main physical symptom improved but not resolved	Better emotionally, main physical symptom improved but not resolved			
15	"I would like to have been able to report bigger changes" (L 125)	No change	No change			
16	"I have responded positively to the treatment" (L 57)	Better physically and emotionally	Better physically and emotionally			
17	"helped me to cope better" (L 38 )	Better emotionally	Better emotionally			
18	"there's a healing taking place and it's fairly holistic" (L 38)	Better physically and emotionally	Better physically and emotionally			
19	"the positive effects came into force more gradually" (L 38)	Better physically and emotionally	Better physically and emotionally			
20	"a wonderful sensation, something is working" (L 55)	Better physically and emotionally	Better physically and emotionally			

### **3.6 DATA GATHERED FROM MYMOP QUESTIONNAIRES**

Participants were asked to complete the MYMOP questionnaires (see Appendix 14) at the beginning of each of the four consultations. All 20 participants completed all questionnaires. The process of asking participants to complete the questionnaires at each consultation was part of a useful routine at the beginning of the consultation, requiring them to reflect on their initial chosen symptoms and their current assessment of their severity. Familiarity with the questionnaires was also helpful as individuals became more aware of scoring symptoms and well being. For research purposes the four questionnaires provided interesting data showing progress over time and at different time points in the homeopathic process. The changes for individuals were variable depending on their response to different remedies and changes in their health and personal circumstances which had an impact on their responses to the MYMOP questionnaire. Comparisons with case notes also provided useful explanations for some of the responses, but overall the most useful data for answering the research questions for this study were the first and the final MYMOP questionnaires which show the changes in health and well being for the complete period of treatment. Detail of responses to questionnaires completed at the second and third appointments is included in the attached CD-rom.

The questions asked in the MYMOP questionnaire focus on specific symptoms chosen by the respondents and on a single activity that they wish to be able to carry out more easily. They were also asked to measure their well being during the previous week. The participants were asked to identify the duration of symptoms and to report on the use of medication for the identified symptoms. Respondents were also asked to score the importance to them of reducing the amount of medication taken or avoiding medication altogether. MYMOP scores are rated on a Likert scale from 0 to 6, 0 indicating ‘as good as it could be’ and 6 indicating ‘as bad as it could be’.

All data collected in MYMOP questionnaires was coded and entered into SPSS v16. Frequency tables were used to check the data quality and missing values coded as

missing. The data entered into SPSS is available on the CD-rom attached to this document. In order to present a clear comparison of results, data was entered into an Excel 97 – 2003 Worksheet and comparative bar charts were produced showing changes over time for all participants.

The analysis of data covers:

- ❑ the identified symptoms and a summary of outcomes
- ❑ descriptive statistics for responses to MYMOP questions for symptoms 1 and 2, for a chosen activity and for perceived well being during the previous week
- ❑ duration of symptoms
- ❑ responses to questions about medication

### **3.6.1 Selection of symptoms and activities**

Participants were asked to identify symptoms in the MYMOP questionnaire at the beginning of their first homeopathic consultation. This was before they had been given an account of the homeopathic process and the type of information that is important in selecting a homeopathic remedy. Most participants identified specific symptoms of the type that might be reported to their GP and consistently reported on these symptoms throughout the study. During the homeopathic consultations, however, the description of what was happening in their lives was more holistic and a different perspective on their symptoms was given. In some cases pain was the identified symptom but the reason given in the consultation for seeking homeopathic treatment was an emotional problem. Some participants changed the symptoms in the MYMOP questionnaire at later consultations, although they were given reminders to use the same information each time they completed the questionnaire. In one case, the first symptom chosen at the first appointment was resolved and the participant was reluctant to go on recording something in later questionnaires that she was no longer experiencing.

Participants were asked to choose an activity, physical, social or mental, that was important to them and score how difficult it had been to carry out that activity in the last week. Participants chose a range of physical activities, such as walking and gardening. Some identified problems with thinking and organising paper work or general emotional issues such as not enjoying life. Participants were not consistent in choosing the same activity each time they completed the questionnaire and did not choose comparable activities each time. Some participants chose activities that were very important to them as individuals but were unlikely to improve.

Participants were also asked to rate their general feeling of well being during the previous week using the same seven point scale. This was the only question about health that was common to all participants. All other questions related to their experience of specific symptoms. For this reason the question on well being provides a common marker for all participants in this study of change over time in a common issue. Although the question was common to all participants, this did not ensure an objective measurement of well being as each participant could have a different view of what was being measured.

Individuals did give indications in the case notes of information that would distort the MYMOP results. For example, one participant reported improvement in symptom 1 in MYMOP but credited it to chiropractic treatment in her case notes. Another participant only included one symptom in MYMOP and recorded no change in the symptom over the treatment period. In his case notes he noted significant improvement in well being as a result of homeopathic treatment and some improvement in his identified symptom 1.

The results for this study do, however, show evidence of improvement for individuals and generalised improvement for the group, despite some inconsistencies in the data.



### 3.6.2 Summary of responses to MYMOP questionnaires

The scores given at the first appointment (A1) and the final appointment (A4) are recorded in the table below for symptom 1 and 2 and for well being (WB). The scores range from 6, 'as bad as it could be', to 0, 'as good as it could be'. Each line represents responses from one participant.

**Table 15: Summary of responses to MYMOP questions on symptoms and well being**

Symptom 1	A1	A4	Symptom 2	A1	A4	Duration	WB A1	WB A4
Asthma	4	2	Anxiety	5	0	5+ yrs	4	0
Loss of smell	5	4	Depression	5	2	4-12 wks	5	3
Back pain	4	N/a	Cough	3	N/a	5+ yrs	4	1
Wrist pain	3	1	Sleep	4	3	4-12 wks	1	2
Gloomy	2	2	Hip pain	4	4	1-5 yrs	3	3
Spinal pain	6	3	Fatigue	6	4	5+ yrs	5	3
Arthritis	0	0	Blood pressure	0	0	1-5 yrs	1	1
Joint pain	2	4	Headache	3	3	5+ yrs	3	3
Shingles	3	0	Anxiety	5	2	0-4 wks	5	1
Back pain	3	1	Shoulder pain	5	4	1-5 yrs	3	3
Back pain	2	1	Irritable	3	1	1-5 yrs	3	2
Shoulder pain	3	0	Waking at 3am	3	2	5+ yrs	2	0
Joint pain	2	2	Poor sleep	2	2	5+ yrs	1	1
Sinusitis	3	3	None	N/a	N/a	5+ yrs	1	1
Digestion	3	3	Anxiety	3	2	1-5 yrs	2	3
Elbow pain	5	2	Knee pain	4	1	3mths-1 yr	3	2
Shoulder pain	1	2	Stress	3	3	1-5 yrs	3	2
Stiff joints	2	1	Heaviness	3	1	1-5 yrs	1	0
Anxiety	4	2	Diarrhoea	3	2	1-5 yrs	4	1
Hot flushes	4	1	Sweating, irritability	5	1	1-5 yrs	3	1

The raw data from MYMOP questionnaires in Table 15 provides information about the symptoms chosen by participants and their well being, with scores for appointments 1 and 4. The duration of symptoms is also given. The data for all appointments was entered into SPSS and is used in later sections to compare outcomes at different times and for different participants (see CD-rom for SPSS v 16 data).

Table 15 indicates that for 12 participants symptom 1 improved, four reported no difference, and two reported worsening symptoms. One participant did not provide a score for symptom 1 at the fourth appointment and one participant scored 0 for all items, as if she had misunderstood the scoring system. One participant identified joint pain generally as the condition she wished to improve. At the third and fourth appointment she noted the return of a former condition involving specific joint pain and scored this as a worsening of joint pain generally.

13 participants indicated that symptom 2 had improved. 12 of these participants also said that symptom 1 improved. Of those who did not report an improvement in symptom 2, one identified her symptom as hip pain. Although she had entered it on the MYMOP questionnaire it was not a reason for her seeking homeopathic treatment. One participant who reported positive outcomes for treatment in other measures used in this study, had selected 'stress' as her second symptom and at the time of the fourth appointment her role at work had become increasingly difficult.

It is not always possible to give explanations for responses to questionnaires in research studies. In this case, as the quantitative data was used to support evidence from the qualitative data it seems relevant to show that there are circumstantial reasons for specific scores, as well as an element of untrustworthiness in the data. This may be attributable to the selection of specific symptoms and a single well being activity rather than using more holistic measures of health outcomes. The MYMOP results were, however, similar to responses in other measures in this study and indicative of general trends for all results.

### 3.6.3 Comparisons for MYMOP data over time and for individuals

All the data from the MYMOP questionnaires was entered into SPSS v16 and analysed. This made it possible to compare results for the whole group and for individuals at different time points. The data for symptom 1 and 2 at the first and fourth appointment is presented first. This is followed by the data on the chosen activity, the well being question, duration of symptoms and use of medication.

The following bar chart shows participant scores for symptom 1 (S1) at the first appointment (A1) and the fourth and final appointment (A4).

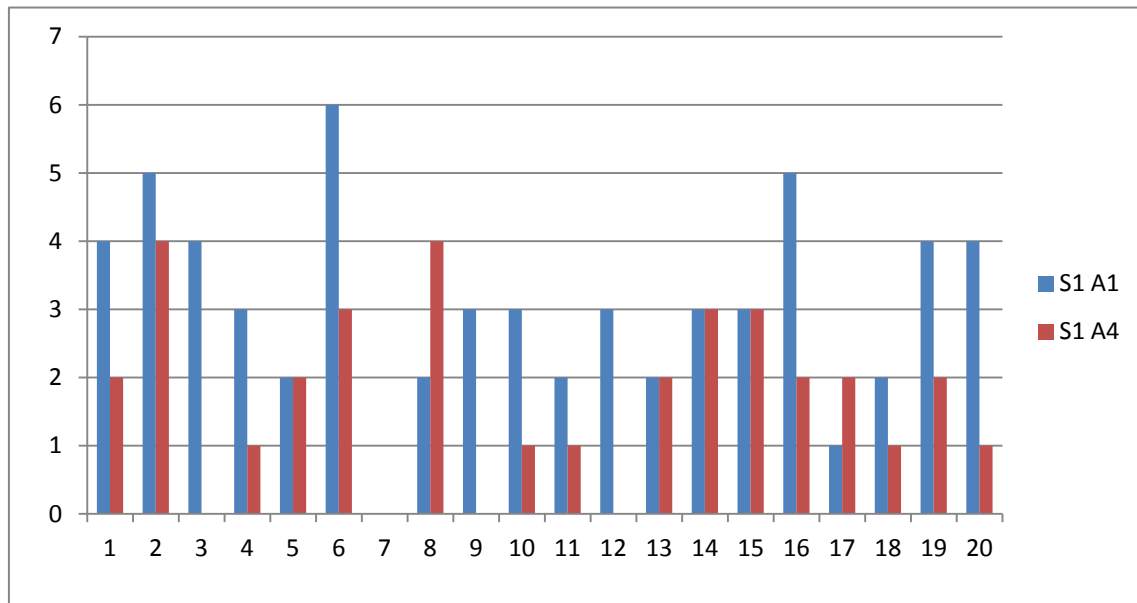


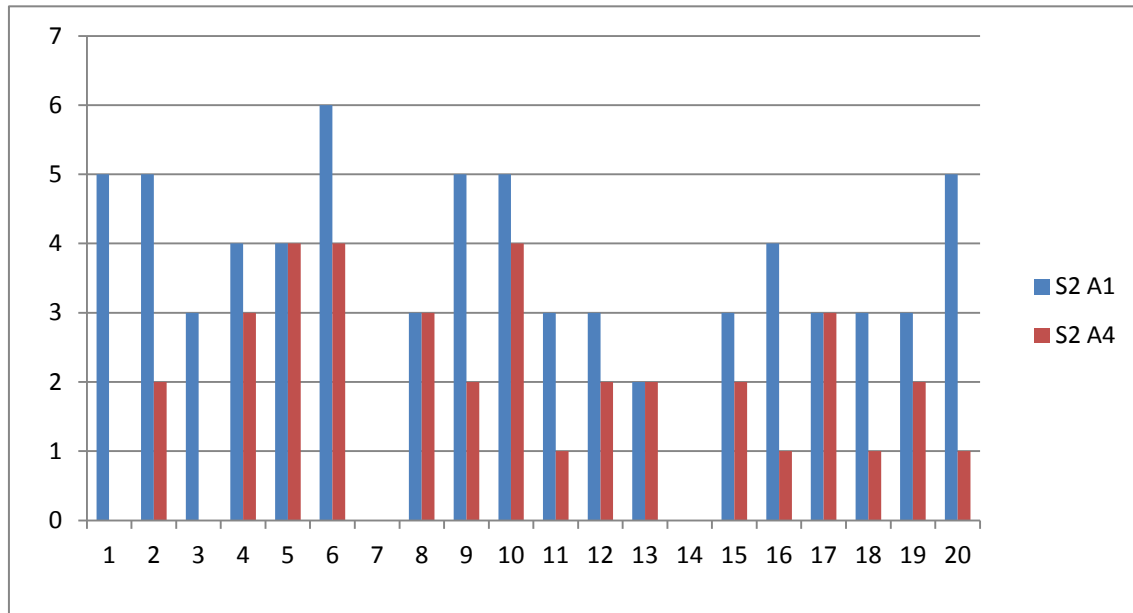
Figure 7: Comparison of scores for symptom 1 for first and fourth appointment

The bar chart in Figure 7 shows that 12 participants scored lower for the fourth appointment than for the first appointment indicating improvement in this symptom. There was no change in the scores for symptom 1 for four participants and an apparent error in scoring for P3 and P7. Two participants scored higher for the fourth appointment indicating a worsening of symptoms. Overall 60% of participants showed improvement at the end of the treatment process for symptom 1.

Figure 7 also shows that at the final appointment nine participants scored their first symptom in the category ‘as good as it could be’ or nearly as good as it could be. Nine participants show an improvement in scores of two or more points on the scale. The number of participants in the categories almost or ‘as good as it could be’ increased to 13. The numbers who scored their symptoms almost or ‘as bad as they could be’ is reduced to two (P2 and P8).

The bar chart in Figure 7 also shows individual participant scores for symptom 1. For example, P16 scored 5 for symptom 1 at the first appointment but 2 at the final appointment. Similarly P20 had a three point increase in her scores showing a big change in her perception of how she viewed symptom 1 between the first and the fourth appointment. In contrast, P2 scored 5 for symptom 1 at the first appointment and 4 at the final appointment (P2 did not take the homeopathic remedy). P5, P13, P14 and P15 scored the same at both appointments, indicating no change in their perception of the severity of symptom 1 over the treatment period.

The following bar chart shows the same comparison for symptom 2 in MYMOP.

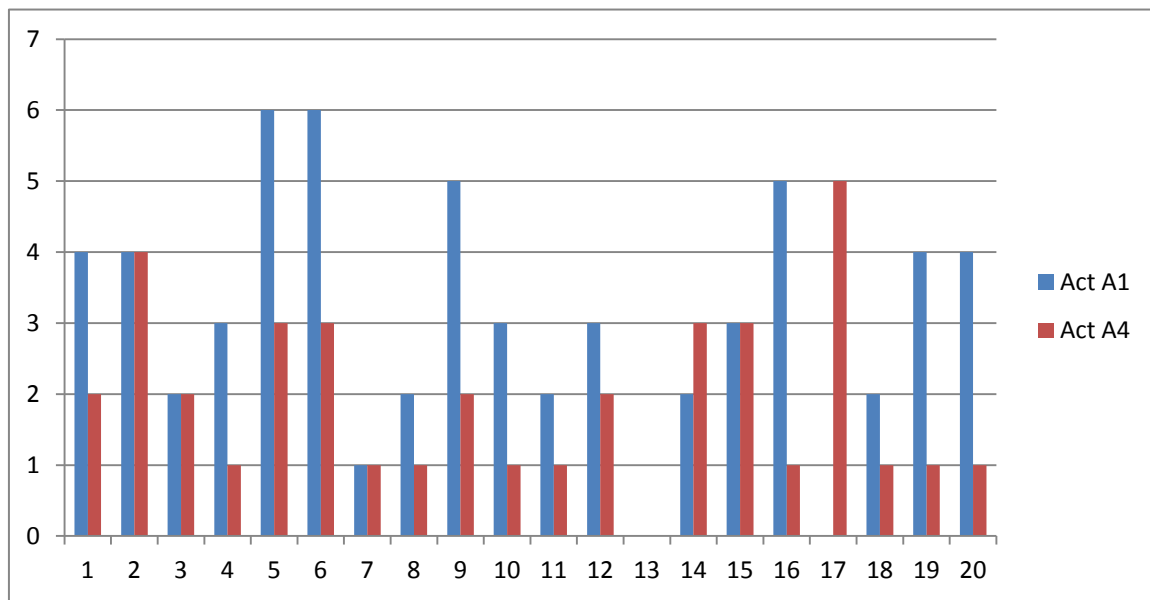


**Figure 8: Comparison of scores for symptom 2 for first and fourth appointment**

The bar chart in Figure 8 shows that 13 participants scored lower for the fourth appointment than for the first appointment indicating improvement in this symptom. There was no change in the scores for symptom 2 for four participants, an apparent error in scoring for P3 and P7 and no second symptom for P14. No participants scored higher for the fourth appointment indicating that no one experienced worsening of symptoms. Overall 65% of participants showed improvement at the end of the treatment process for symptom 2.

Figure 8 also shows that at the final appointment the number of participants in the categories almost or ‘as good as it could be’ increased to 11. Eight participants show an improvement in scores of two or more points on the scale. There is evidence of positive changes in the severity of symptoms for a number of participants. P1 for example, scored 5 at the first appointment and 0 at the final appointment.

Figure 9 below shows participant responses to the MYMOP question on activities that they felt were limited because of their health issues. Individuals chose a wide variety of activities, including physical exercise such as gardening, but also mental tasks and the ability to manage situations. These diverse choices generally matched comments made in the case notes about lack of motivation to achieve things that mattered to them as individuals.



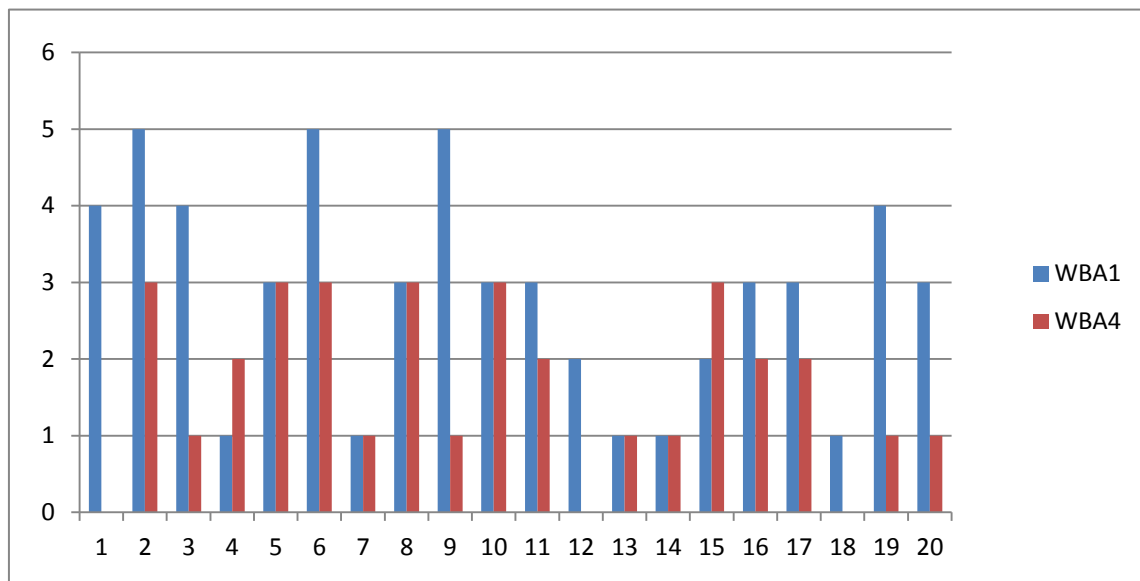
**Figure 9: Scores for ability to carry out chosen activity at the first and fourth appointment**

Figure 9 shows that 13 participants reported an improvement in the ability to carry out their chosen activity. Four participants reported no change and two participants reported that they were less able to carry out the activity. One participant did not complete this part of the questionnaire. 65% of participants recorded an improvement in their ability to carry out their chosen activity between the first and the fourth appointment.

There were individual examples of noticeable improvement in the ability to carry out the chosen activity. For example P16, P19 and P20 moved from ‘almost as bad as it could be’ to ‘as good as it could be’. P17 scored much worse at the fourth appointment than at the first because she was less able to carry out her chosen activity, which was swimming. She

reported in consultations that pressure of work and lack of time rather than health issues prevented her from carrying out her chosen activity.

Participants were also asked to score their general feeling of well being in the previous week. The bar chart in Figure 10 shows the changes that took place in response to this question between the first and final appointment.



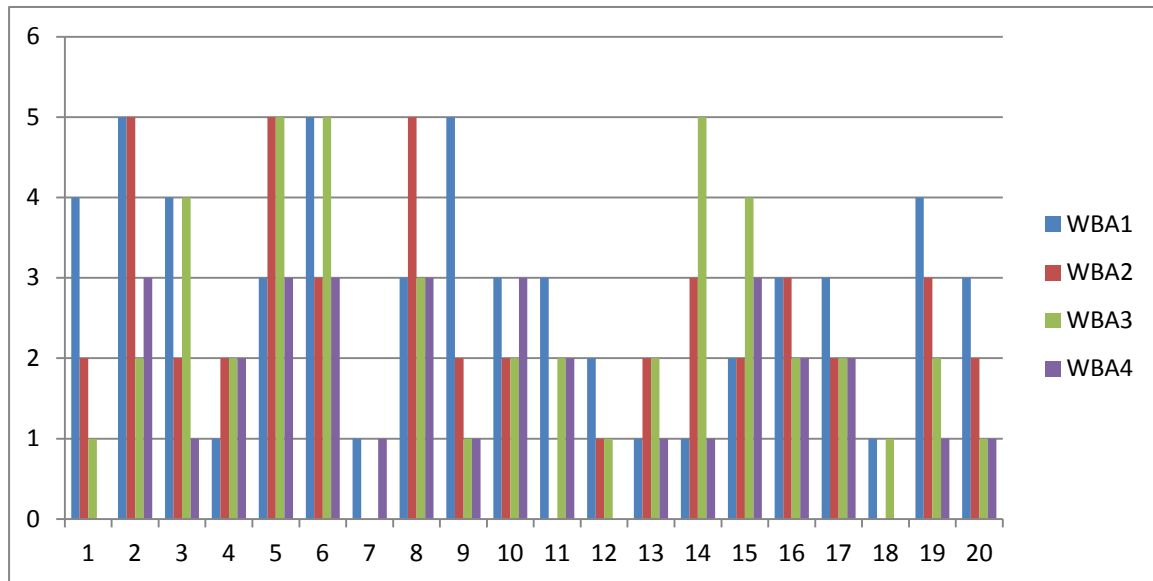
**Figure 10: MYMOP well being scores for participants at the first and fourth appointment**

Figure 10 shows that 12 participants experienced an improvement in well being between the first and the fourth appointment. Six participants experienced no change and two participants felt that their well being was worse during the previous week.

Individual participants show noticeable changes in wellbeing. P3, P9, and P19, for example, all move from almost ‘as bad as it could be’ to almost ‘as good as it could be’.

The well being question related to the week before the questionnaire was completed. It was the only question that was common for all participants. It therefore seemed relevant to make a comparison between the four appointments to see if there were any noticeable changes in the responses from participants. It can be seen in Figure 11 that at the first

appointment eight participants were in the middle of the scale for well being, six participants were almost ‘as bad as it could be’ and six participants were almost ‘as good as it could be’.



**Figure 11: Comparison of MYMOP well being scores for all appointments**

By the time of the second appointment, this had changed to four participants in the middle of the scale (P6 and P14, P16 and P19), three participants were in the ‘as bad as it could be’ (P2, P5 and P8) category and 11 participants in the almost ‘as good as it could be’. Only 18 participants responded to this question at the second appointment. The trend at the second appointment showed some improvement in well being.

At the third appointment the responses changed again. One participant described well being as ‘as good as it could be’ (P7) and 13 participants selected almost ‘as good as it could be’. Only one person was in the middle category (P8) and five people selected almost ‘as bad as it could be’. The change for P4 may have been related to a bereavement experienced at the time of completing the form.

The final appointment showed a similarly positive change. Three people indicated that their well being was ‘as good as it could be’ (P1, P12 and P18) and 11 participants said



that it was almost ‘as good as it could be’. Six participants were in the middle category and no one indicated that their well being was almost or ‘as bad as it could be’.

These indications of change in well being over time suggest that most participants scored their well being higher at the end of the treatment process than at the beginning. It is possible that individuals were inconsistent in scoring their well being at each appointment, but overall it seems as if the well being question in the MYMOP questionnaire produced a positive response for perceived well being for participants in this study.

### **3.6.4 Duration of symptoms**

The MYMOP questionnaire asked participants to identify how long they had experienced their chosen symptoms. The table below summarises their responses to this question.

**Table 16: Duration of symptoms for participants in study**

<b>Duration of symptoms</b>	<b>0 – 4 weeks</b>	<b>4 – 12 weeks</b>	<b>3 mths – 1 year</b>	<b>1 – 5 years</b>	<b>Over 5 years</b>
<b>No of participants</b>	1	2	1	9	7

Table 16 shows that most symptoms had existed for a considerable period of time before homeopathic treatment began. 16 participants had experienced symptoms for more than one year and seven of the participants had experienced symptoms for more than five years.

The fact that 16 participants had experienced symptoms for longer than a year, and seven of these participants had experienced symptoms for more than five years indicates the level of chronic ill health and the lack of resolution of symptoms in that period of time. Table 15 summarised the outcomes of treatment and the duration of symptoms. There is

no clear connection between the length of time that participants experienced symptoms and the improvement in these symptoms in the treatment period. For example, one participant reported experiencing symptoms for more than five years but also reported significant improvement in both symptom 1 and symptom 2. Another participant experienced symptoms for less than a year but also reported a significant improvement in symptoms during the treatment period. In contrast, a third participant experienced no change in symptoms she had experienced for more than five years.

### **3.6.5 Analysis of responses to questions on medication**

The MYMOP questionnaire also asked participants to identify any medication that they were taking for the symptoms chosen. (In some cases, other medication was identified in case notes for symptoms other than those identified in MYMOP.) Eight participants confirmed that they were taking medication for the identified symptoms at the first appointment. One participant stopped the medication after the first appointment, but all others continued to confirm that they were taking medication prescribed by their GP. Ten participants confirmed that they were not taking medication for their chosen symptoms and this response was repeated in all four questionnaires. Two participants did not respond to the questions on medication. Seven participants said ‘yes’ they were taking medication at the first appointment for the identified symptoms and this dropped to two at the fourth appointment. This is important for individuals whose choice was to reduce their use of medication but may also be important when considering the financial cost of treating this age group with pharmaceutical medicines.

Participants were also asked to confirm if cutting down on medication was important to them and also if avoiding medication was important. Some participants did not complete these questions or marked them as not applicable. For those who answered, six participants felt it was important to cut down on medication and nine participants thought it was very important to avoid medication.

**Table 17: Participant responses on the importance of cutting down or avoiding medication**

	Not important	Bit important	Very important	Not applicable
<b>Cutting down on medication</b>		1	6	7
<b>Avoiding medication</b>	1	2	9	2

In summary, MYMOP is a patient centred outcome measure focusing on symptoms chosen by individual participants in the study. It therefore reflects perceptions of changes in health rather than providing an objective measure of health status. In this study, there is evidence that it reflects positive trends in the response to homeopathic treatment. For symptom 1, 12 participants reported an improvement and for symptom 2, 13 participants reported an improvement. For the common question on well being, there was similar evidence of improvement in well being for most participants.

### **3.6.6 Statistical analysis of MYMOP data**

The quantitative data produced from the MYMOP questionnaires reflects similar outcomes to the quotes and perceptions collected from the qualitative data for each of the participants. The size of the study population and the type of data collected suggested that further statistical analysis was unlikely to produce useful evidence. Participants presented a range of symptoms, some not associated with their reasons for seeking homeopathic treatment. There was also some missing data and errors in completing the questionnaire. In a larger study, these inconsistencies may be less important but in this study it was felt that the descriptive data provided the most honest account of the findings from the MYMOP questionnaire. The quantitative data collected from both MYMOP and SF-36 was designed to support the qualitative data and not to provide statistical evidence of treatment outcomes. The research questions focus on the perceived effectiveness of homeopathic treatment and evidence of this is most clearly presented in the qualitative data.

Selected outcomes from MYMOP questionnaires are summarised in tables 18 and 19. The score included in the table is the one that indicated the most change for each participant. Scores are provided for appointment one and four because these show the initial scores and the final scores for participants in this study, rather than the interim scores recorded at appointments two and three, which reflect changes during the process of treatment rather than final outcomes.

### 3.6.7 Summary of outcomes including MYMOP questionnaire

Table 18: P1-10, summary of selected outcomes from the MYMOP questionnaire

	Participant interviews	Participant case notes	Homeopath's perspective	MYMOP (better > or worse <)	SF-36 PCS	SF-36 MCS
1	"definitely made me much calmer, I'm not so anxious" (L 73)	Better physically and emotionally	Better physically and emotionally	Symptom 2 better 5 > 0		
2	"I wasn't allowed to take a remedy" (L 30)	Improving using anti depressants and self care	Better emotionally	Symptom 2 better 5 > 2		
3	"I coped better" (L 51)	Better physically and emotionally	Better physically and emotionally	Improved well being 4 >1		
4	"It really worked for me almost right away" (L 38 )	Better physically	Better physically	Symptom 1 better 3 > 1		
5	"overall I've made definite progress" (L 48)	Better emotionally	Better emotionally	No change		
6	"the first remedy it was good, it had a positive effect in the house" (L 50)	Improvement in mood, sleep, energy	Improving but not better	Symptom 1 better 6 > 3		
7	"incredible, what an improvement" (L 55)	Better physically and emotionally	Better physically and emotionally	No change		
8	"took away my headaches" (L 41)	Improvement in headaches on first remedy.	Improvement in headaches on first remedy.	Symptom 1 worse 2 < 4		
9	"back to a greater sense of commitment to life" (L 63)	Better physically and emotionally	Better physically and emotionally	Symptom 2 better 5 > 2		
10	"my back is a huge lot better" (L 48)	Better physically	Better physically	Symptom 1 better 3 > 1		

**Table 19: P11-20, summary of selected outcomes from the MYMOP questionnaire**

	<b>Participant interviews</b>	<b>Participant case notes</b>	<b>Homeopath's perspective</b>	<b>MYMOP (better &gt; or worse &lt;)</b>	<b>SF-36 PCS</b>	<b>SF-36 MCS</b>
11	"I'm more on an even keel now" (L 40)	Some improvement	Improving	Symptom 2 better 3 > 1		
12	"Fascinating" (L 41)	Better physically and emotionally	Better physically and emotionally	Symptom 1 better 3 > 0		
13	"arthritis was my thing in my wrists ....and it's certainly easier" (L 48-49)	Improvement in sleep and joint pain	Minor improvement	No change		
14	"the general feeling of goodness and feeling well" (L 62)	Better emotionally, main physical symptom improved but not resolved	Better emotionally, main physical symptom improved but not resolved	No change		
15	"I would like to have been able to report bigger changes" (L 125)	No change	No change	Symptom 2 better 3 > 2		
16	"I have responded positively to the treatment" (L 57)	Better physically and emotionally	Better physically and emotionally	Symptom 1 better 4 > 1		
17	"helped me to cope better" (L 38 )	Better emotionally	Better emotionally	Symptom 1 worse 1 < 2. well being better 3 > 2		
18	"there's a healing taking place and it's fairly holistic" (L 38)	Better physically and emotionally	Better physically and emotionally	Symptom 2 better 3 > 1		
19	"the positive effects came into force more gradually" (L 38)	Better physically and emotionally	Better physically and emotionally	Symptom 1 better 4 > 2		
20	"a wonderful sensation, something is working" (L 55)	Better physically and emotionally	Better physically and emotionally	Symptom 2 better 5 > 1		

### **3.7 DATA GATHERED FROM SF-36 QUESTIONNAIRES**

Participants were asked to complete SF-36 (short version 2) questionnaire (see Appendix 15) at the beginning of each of the four consultations. All 20 participants completed all questionnaires. Most respondents successfully completed all SF-36 questionnaires but responses to some questions were omitted and these were described as missing data. A potential difficulty arose when respondents had become accustomed to circling a number or answer on one side of the page. When the questions were asked negatively rather than positively the scores were reversed and this may have led to errors in scoring responses.

The scores for SF-36 questionnaires for each participant in the study were reviewed for each of the four homeopathic consultations ie 80 scores. (See attached CD-Rom for complete set of data.) All data collected in SF-36 questionnaires was coded and entered into SPSS v16. Frequency tables were used to check the data quality and missing values coded as missing.

All questionnaires, four for each of the 20 participants, were scored using the SF-36v2™ Health Survey Scoring Demonstration (Quality Metric 2009). Scores for SF-36 are calibrated so that 50 is the average score or norm. This norm based score allows comparisons with other studies. Scores for SF-36 range from 0 to 100, with the higher scores indicating better health.

Composite scores for all responses to SF-36 questions were entered into SPSS v 16 and reviewed to show any change that had taken place at each of the four appointments. In order to present a clear comparison of results, data was entered into an Excel 97 – 2003 Worksheet and comparative bar charts were produced showing changes over time for all participants.

### **3.7.1 Composite scores for all responses to SF-36 questionnaire**

Composite scores for all responses to the SF-36 questionnaire are presented for each of the following categories of health and well being:

PF = Physical Functioning

RP = Role Physical

BP = Bodily Pain

GH = General Health

VT = Vitality

SF = Social Functioning

RE = Role Emotional

MH = Mental Health

PCS = Physical Component Summary

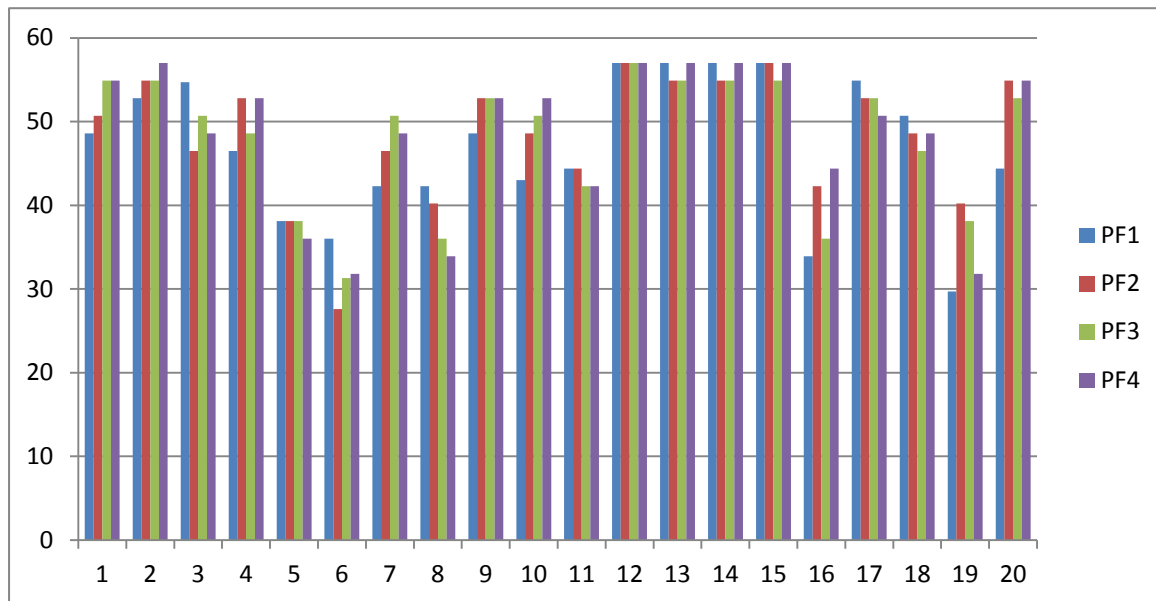
MCS = Mental Component Summary

#### **3.7.1.1 Physical functioning (PF)**

The scoring system for SF-36 (Quality Metric 2009) amalgamates scores for different questions in similar categories, beginning with physical functioning (PF). Question 3 in the SF-36 questionnaire on physical functioning describes activities ranging from vigorous activities such as running (question 3a), to daily tasks such as bathing and dressing (question 3j). Respondents are asked if they are ‘limited a lot’, ‘limited a little’ or ‘not limited at all’ in carrying out these activities. In this study most participants reported some limitation on vigorous activity and no limitation on bathing and dressing. The other items in questions 3b to 3i asked about scaled levels of physical ability including lifting and carrying, climbing stairs, bending, kneeling or stooping and walking different distances.



The bar chart in Figure 12 shows the composite scores for each participant for each appointment for physical functioning.



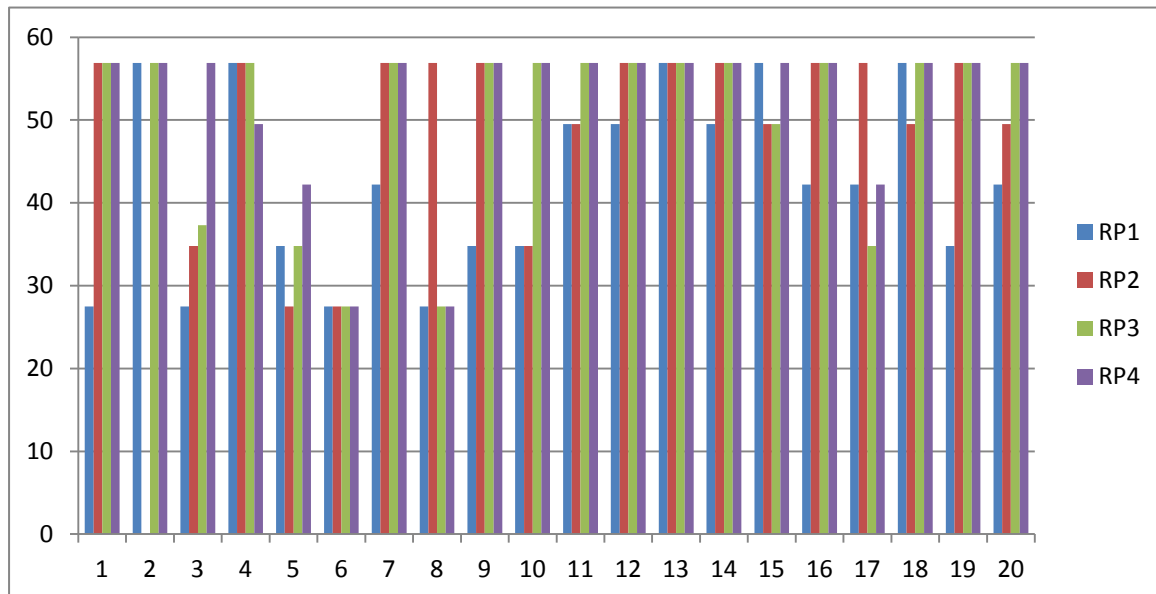
**Figure 12: SF-36 scores for participants' responses to questions on physical functioning**

Figure 12 shows that the physical functioning of nine participants improved between the first and the fourth appointment. There was deterioration in physical functioning for seven participants and no change for four participants. The change for individuals over the four appointments is not very large but for some participants changes correspond well with information provided at appointments about the state of their health. For example, P8 developed a frozen shoulder towards the end of the treatment process which limited physical functioning. P12 presented with mainly emotional issues, regarding herself as physically fit from the beginning of the homeopathic process, and her scores remained the same for all appointments.

The health problems identified by the individuals who showed an improvement in physical functioning included a range of physical and emotional symptoms and therefore improvement in physical functioning seems to be linked to an improvement in health generally.

### 3.7.1.2 Role physical (RP)

Question 4 in the SF-36 questionnaire asks about any limitations on the amount of time spent on work or other activities. Respondents are asked to say if they cut down on the amount of time spent on work or other activities, accomplished less, were limited in the kind of work they could do or had difficulty performing the work or other activities. In this study, scores remained the same or there was improvement in ability to carry out tasks. There was a noticeable correlation between responses to this question and life events such as bereavement. The bar chart below shows the composite scores for all participants for all four appointments for role physical.



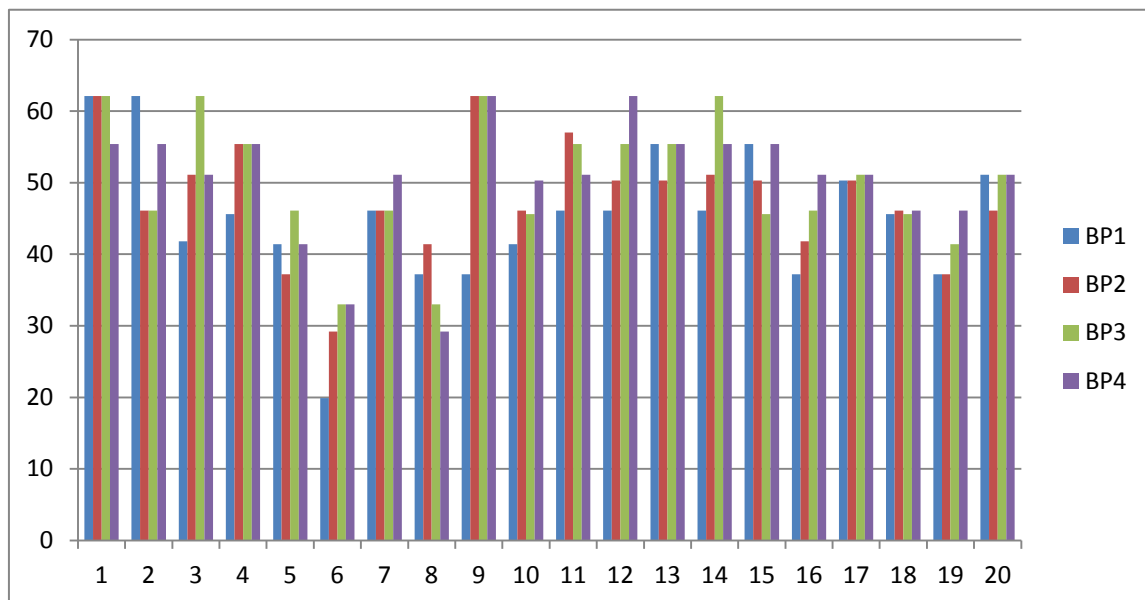
**Figure 13: SF-36 scores for participants' responses to questions on role physical**

Figure 13 shows that between the first and the fourth appointment 12 participants reported an improvement in role physical over the period of homeopathic treatment. In general the improvement is greater than for physical functioning. There is no change for seven participants and deterioration in role physical for one participant (P4). There is a connection between case notes and individual scores for role physical. P8 for example appeared to do well on the first remedy prescribed and scored very high for role physical

but this improvement did not continue and her scores go down for subsequent appointments. P4 did well as a result of homeopathic treatment generally but suffered a bereavement before the final appointment which caused distress and disrupted her normal life.

### 3.7.1.3 Bodily pain (BP)

Question 7 and 8 in the SF-36 questionnaire ask respondents to assess the amount of bodily pain experienced, ranging from none to very severe pain, and how much this pain interfered with their normal work at home or outside the home. The bar chart in Figure 14 shows composite scores for bodily pain for all participants for all appointments.



**Figure 14: SF-36 scores for participants' responses to questions on bodily pain**

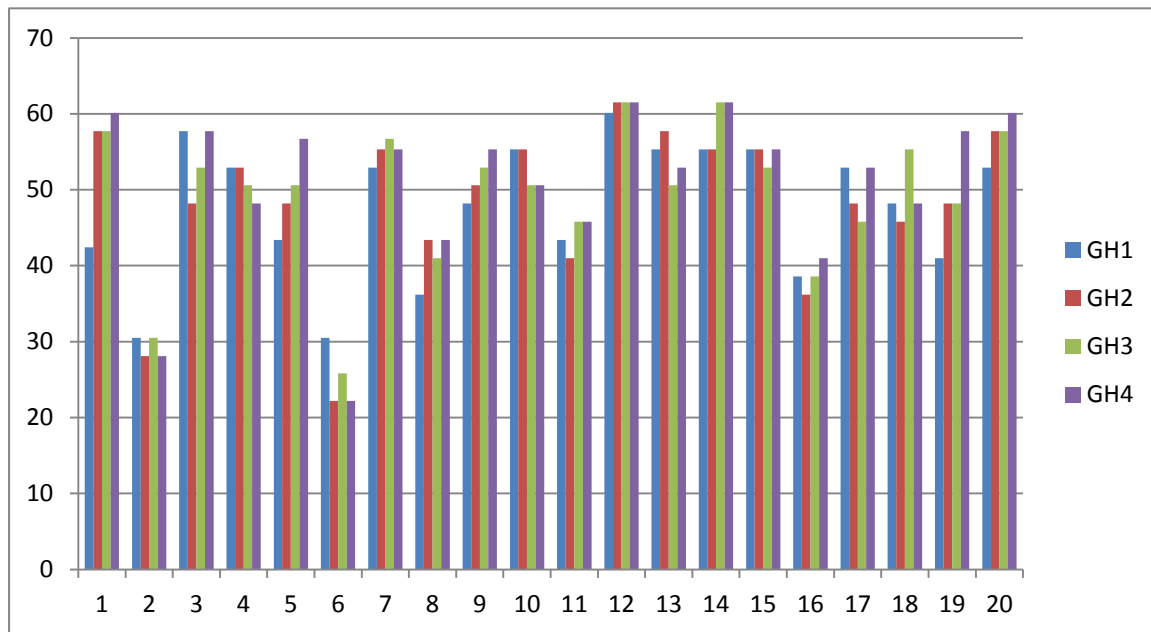
Figure 14 shows that there was improvement in bodily pain for 12 participants in this study between the first and the fourth appointment. This may relate to those participants who experienced improvement in joint pain during the study, but could also refer to participants who experienced pain from sinusitis, headache, digestive problems and other less specific pain, such as nerve pain. Three participants experienced a worsening of

bodily pain (P1, P2 and P8) and five participants experienced no change (P5, P13, P15, P18 and P20).

Individual scores again relate well to descriptions of symptoms given by participants in the case notes. P6 suffered from severe pain and an improvement is recorded here. P16 also shows an improvement. His main symptom was joint pain which prevented him from enjoying activities such as gardening and walking. The recorded improvement here confirms results for P16 in other measures used in this study.

#### **3.7.1.4 General health (GH)**

Question 1 and question 11 in the SF-36 questionnaire ask respondents to measure their general health and their responses are scored together. Their perception of their general health is measured as excellent, very good, good, fair or poor. Their perception of how their health compares to the health of others is graded on a scale from 'definitely true' to 'definitely false' for questions such as 'I am as healthy as anybody I know'. Figure 15 shows that there has been an improvement in some respondents' perception of their general health between the first and the fourth appointment.



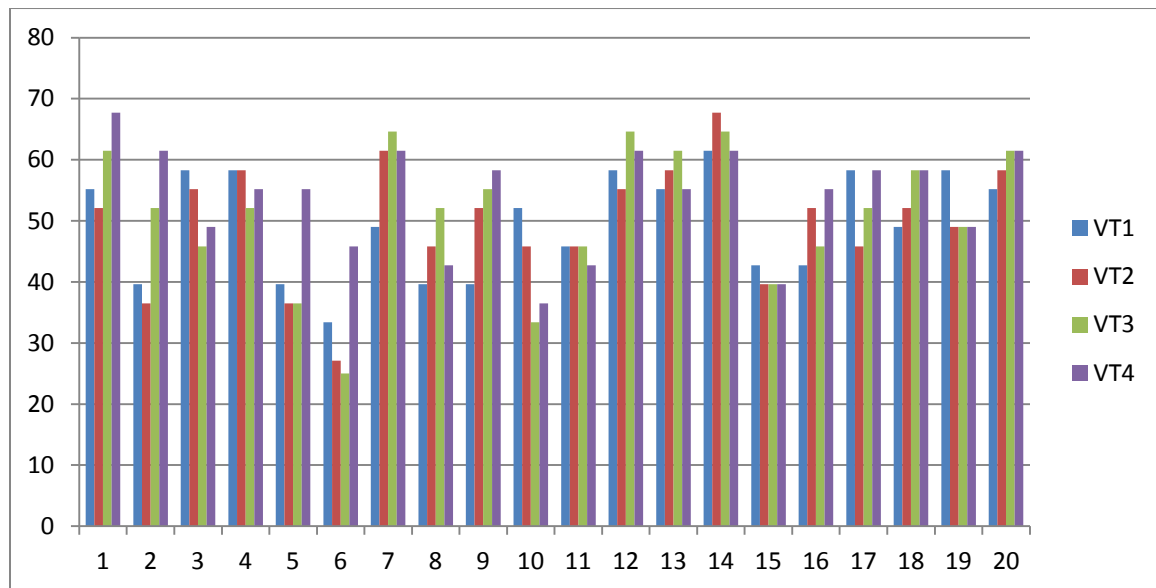
**Figure 15: SF-36 scores for participants' responses to questions on general health**

Figure 15 shows that 11 participants reported an improvement in general health between the first and fourth appointment. For some participants this was a continuing improvement over the four appointments (P1, P5, P9, P19 and P20). The data also reflects the variability of change for some participants (P3, P8, P11 and P18) which is related to both changing personal circumstances and changes in treatment. Five participants reported deterioration in general health (P2, P4, P6, P10 and P13) and four reported no change (P3, P15, P17 and P18).

The improvement recorded for individual participants reflects improvement recorded in other measures in the study. P2, P6 and P15 did not show much improvement in other measures and this is reflected in this analysis of general health scores. Surprisingly P8 shows improvement here, in contrast to the measure of bodily pain which showed a worsening of her score. This compares with an improvement in her well being score in MYMOP and raises the issue of whether more objective measurements of health and well being such as MYMOP and SF-36 capture something that is not expressed in words in the consultations or interviews. P8 described herself as not observant about changes in her health.

### 3.7.1.5 Vitality (VT)

Question 9 in the SF-36 questionnaire asks respondents to measure their vitality by asking them if they felt full of life, had a lot of energy, felt worn out or felt tired, on a scale from 'all of the time' to 'none of the time' in the last month. The bar chart in Figure 16 shows the composite scores for all participants for all appointments for vitality.



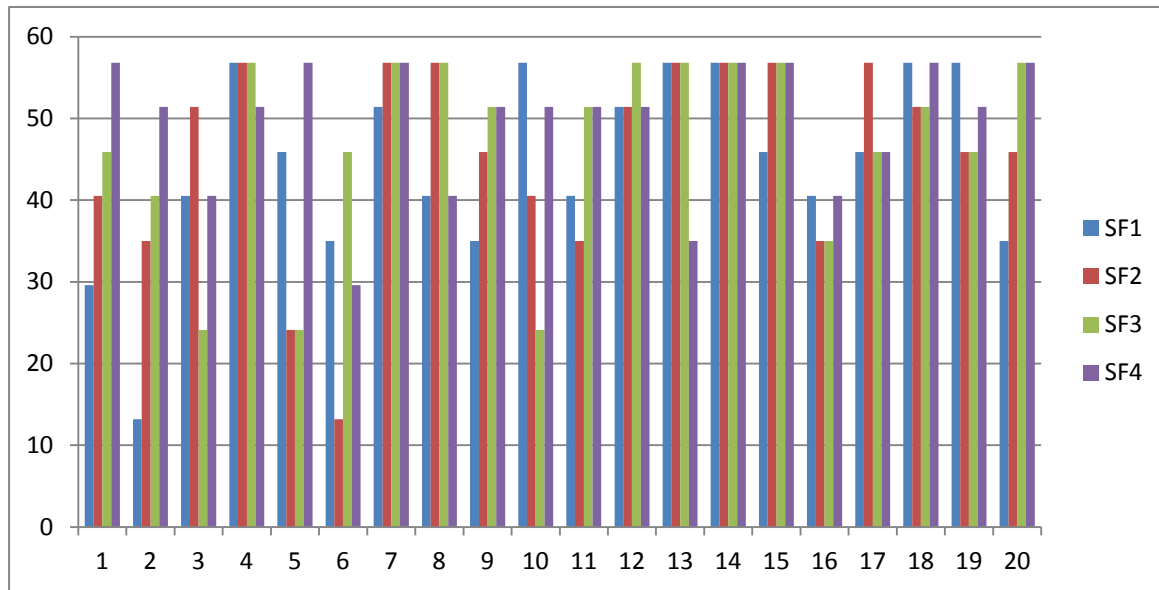
**Figure 16: SF-36 scores for participants' responses to questions on vitality**

Figure 16 shows that in this study there was an improvement in vitality for 11 participants between the first and the fourth appointment. Six participants reported that they had less vitality and three reported no change. Once again, some of the negative changes could be related to bereavement, as in the case of P3, P4 and P10.

### 3.7.1.6 Social functioning (SF)

Questions 6 and 10 in the SF-36 questionnaire ask respondents to measure the extent to which physical or emotional problems have interfered with normal social activities.

Responses to these questions were again affected by life circumstances for participants in this study, particularly bereavement or hospital visiting. The bar chart in Figure 17 shows the composite scores for social functioning for all participants for all appointments.



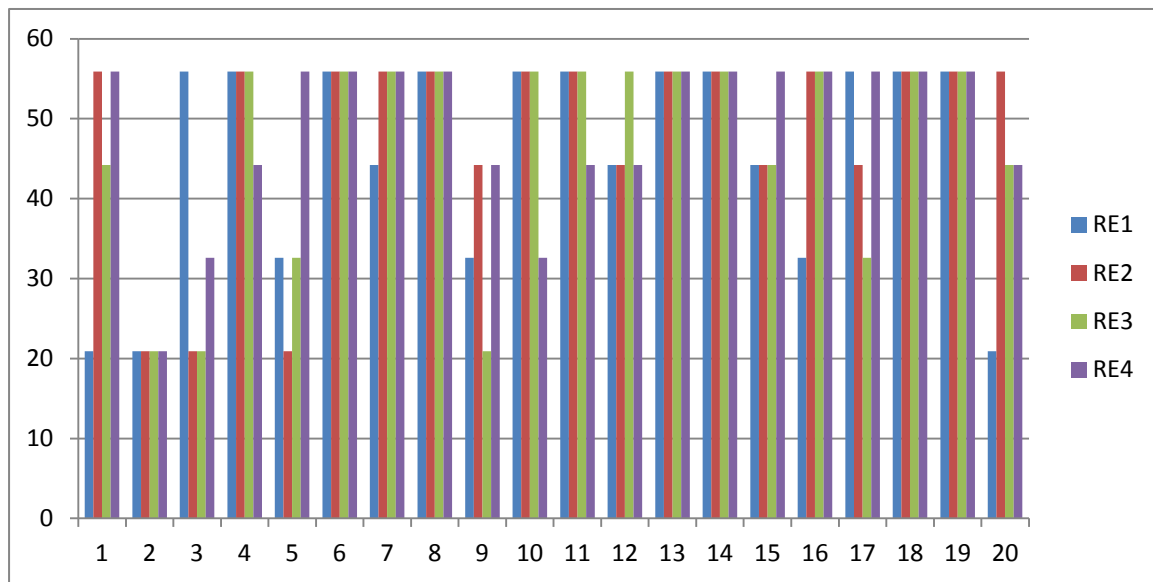
**Figure 17: SF-36 scores for participants' responses to questions on social functioning**

Figure 17 shows that between the first and the fourth appointment eight participants noted an improvement in social functioning. Seven participants noted no change and five experienced deterioration in social functioning. Once again participants who experienced bereavement scored less well in this category at the time of the appointment closest to the bereavement.

The case notes also reflect changes in social life in this age group related to work pressures, availability of social opportunities, a focus on caring roles and individual preferences in terms of social functioning. One measurement of improvement as a result of homeopathic treatment is improvement in relationships and a renewed interest in seeing friends or family. Those who reported this change in case notes are the same participants whose scores improve for social functioning, such as P1 and P20.

### 3.7.1.7 Role emotional (RE)

Question 5 in the SF-36 questionnaire asks respondents if they have cut down on the amount of time spent on work or other activities, or accomplished less than they would like, or did work less carefully as a result of emotional health problems. Respondents rated this on a scale from ‘all of the time’ to ‘none of the time’. The bar chart in Figure 18 shows the composite scores for role emotional for all participants for all appointments.



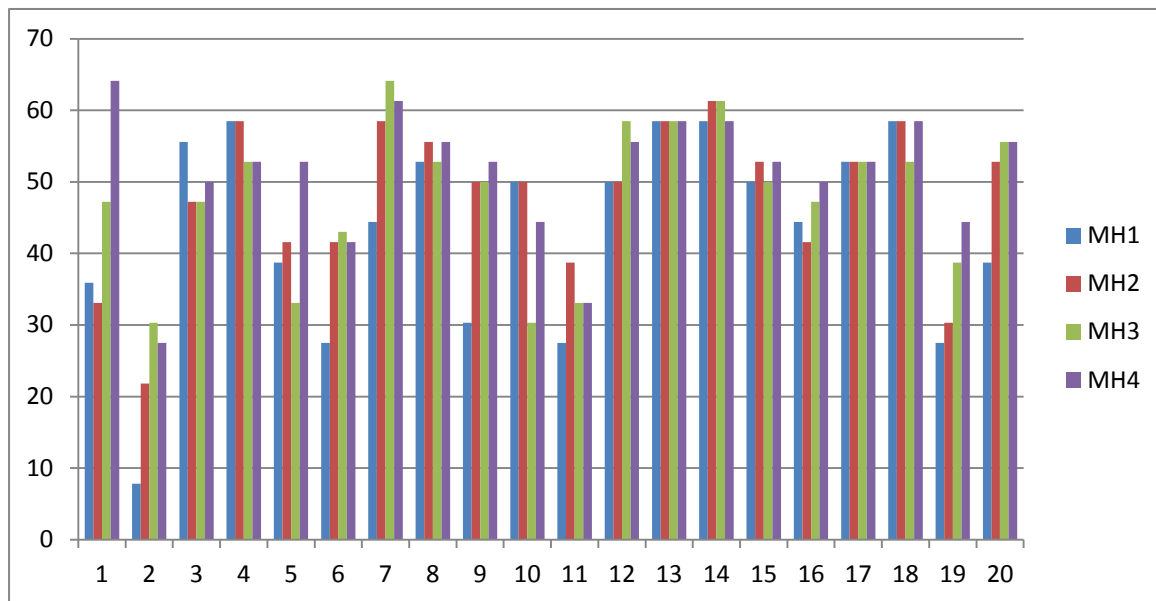
**Figure 18: SF-36 scores for participants' responses to questions on role emotional**

Figure 18 shows that seven participants scored higher for role emotional at the fourth appointment than at the first appointment. Nine participants noted no change in role emotional and four participants (P3, P4, P10 and P11) scored lower for role emotional at the fourth appointment than at the first.



### 3.7.1.8 Mental health (MH)

Question 9 in the SF-36 questionnaire asked respondents to rate their mental health in terms of how nervous they had felt in the preceding four weeks, how down in the dumps they had felt, if they had felt calm, downhearted, depressed or happy. This was rated from ‘all of the time’ through ‘to none of the time’. The bar chart in Figure 19 shows the composite scores for mental health for all participants for all appointments.

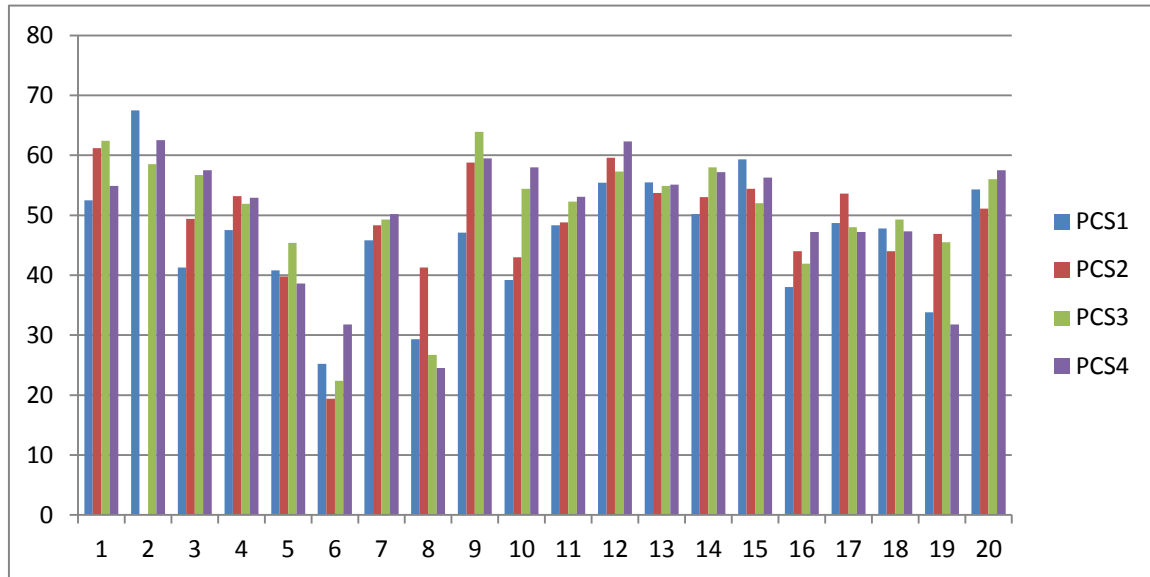


**Figure 19: SF-36 scores for participants’ responses to questions on mental health**

Figure 19 shows that 13 participants scored higher for mental health at the fourth appointment than the first appointment. Three participants scored lower (P3, P4 and P10) and four noted no change in mental health at the fourth appointment (P13, P14, P17 and P18). P13, P14 and P18 rated their emotional well being as good throughout the study and this is reflected in their scores. In contrast, participants who were most depressed, such as P2 and P6, show the greatest improvement in the composite score for mental health.

### 3.7.1.9 Physical component summary (PCS)

The scoring system for the SF-36 questionnaire provides a summary of all responses to questions about physical health. The bar chart in Figure 20 shows the composite score for all participants for all appointments for the physical component summary.



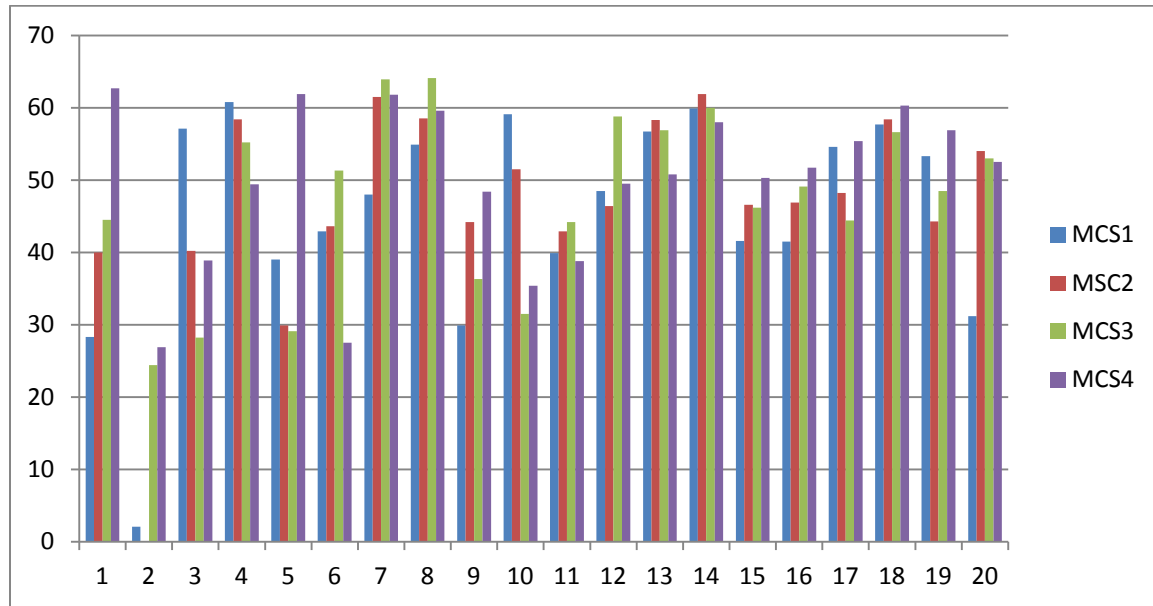
**Figure 20: SF-36 scores for participants' physical component summary**

Figure 20 shows that 12 participants scored higher at the fourth appointment than the first appointment for the physical component summary. Six participants scored lower and there was no change for two participants.

Those participants who show the least change are those who reported the least problems with physical functioning. Those showing the greatest improvement are those who identified joint pain as a key symptom, for example P10 and P16.

### 3.7.1.10 Mental component summary (MCS)

A similar summary is provided for scores for responses to questions about mental health. The bar chart in Figure 21 shows the composite scores for the mental component summary for all participants for all appointments.



**Figure 21: SF-36 scores for participants' mental component summary**

Figure 21 shows that 13 participants scored higher for the fourth appointment than the first appointment for the mental component summary. Seven participants scored lower at the fourth appointment for the mental component summary.

Figure 21 reflects earlier bar charts showing those who had been bereaved scoring lower for emotional well being. Some participants who reported no change in emotional well being scored reasonably high for this from the beginning of the study. Those who showed most improvement included those who scored highly for improvement in mental and emotional symptoms in the MYMOP questionnaire.

### 3.7.2 Scores for individual questions in the SF-36 questionnaire

The questions asked in the SF36 questionnaire focus on:

- ☐ perceptions of health and well being
- ☐ physical well being
- ☐ emotional well being
- ☐ ability to socialise and carry out normal activities

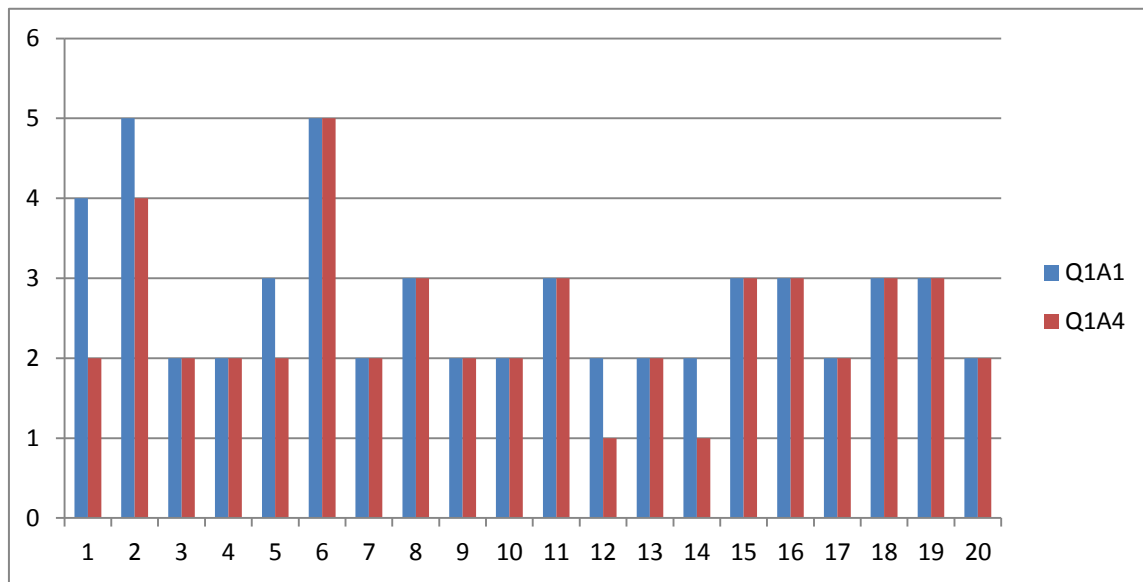
These categories are all relevant when considering outcomes of homeopathic treatment. The composite scores provided by using the SF-36 scoring system gave an overview of responses from participants in the study. More detailed analysis of responses from participants to individual questions in SF-36 provides more specific information about outcomes for each question.

Although analysis of all 36 questions was carried out, the answers to some questions are not included. (See the attached CD-rom for the full analysis of this data.) Some of the questions ask the same thing in a different way, for example asking participants how often they feel tired and also how often they have lots of energy. Other questions were less significant for this particular study, for example questions about limitations on bathing and dressing, as almost all participants stated that there were no limitations on this activity. In contrast questions like question 3f, which asked about the ability to bend, kneel and stoop was very relevant for this study, as participants who experienced problems with joint pain reported limitations on this activity.

The questions selected for presentation here are those that were believed to show most clearly any change in the participants' perception of health and well being, or any change in physical health or any change in mental or emotional health. Questions that are not included are those that showed little or no change throughout the study.

### 3.7.2.1 Perceptions of health and well being

Question 1 of the SF-36 questionnaire asked respondents to rate their health on a six point scale from 'Excellent' to 'Poor' (1 represents 'excellent', 2 'very good', 3 'good', 4 'fair' and 5 'poor'). The bar chart below shows a general improvement in health rating after homeopathic treatment, in response to question 1 of the SF-36 questionnaire.



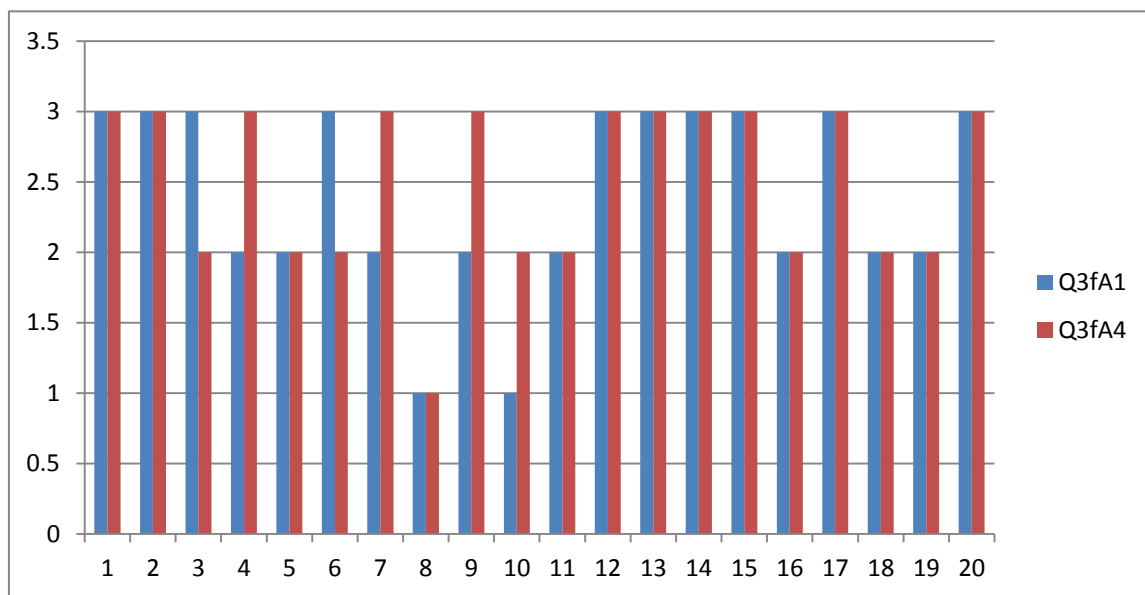
**Figure 22: Responses to question 1 of the SF-36 questionnaire at the first and final appointment**

In Figure 22 five participants show an improvement in their perception of their health and the remainder consider their perception of their health to be the same as before homeopathic treatment. At the first appointment 10 participants rated their health as very good. Two of these participants rated their health as excellent by the fourth appointment.

### 3.7.2.2 Physical well being

Question 3 of the SF-36 questionnaire asks a series of ranked questions about respondents' ability to carry out activities, ranging from vigorous activity to bathing and dressing. Respondents assessed whether their ability to carry out the activities was limited a lot, a little or not at all. Most participants stated that their ability to carry out vigorous activity was limited a lot or a little, but for other activities such as climbing stairs, walking a mile, bathing and dressing, most stated that they were not limited at all.

13 participants identified problems with joint pain in the case notes and the MYMOP questionnaire. The responses to the question on bending, kneeling and stooping in question 3f of SF-36 suggest positive changes in the ability to carry out these activities. In the scoring for question 3f, 1 represents 'limited a lot', 2 'limited a little' and 3 'not limited at all'.

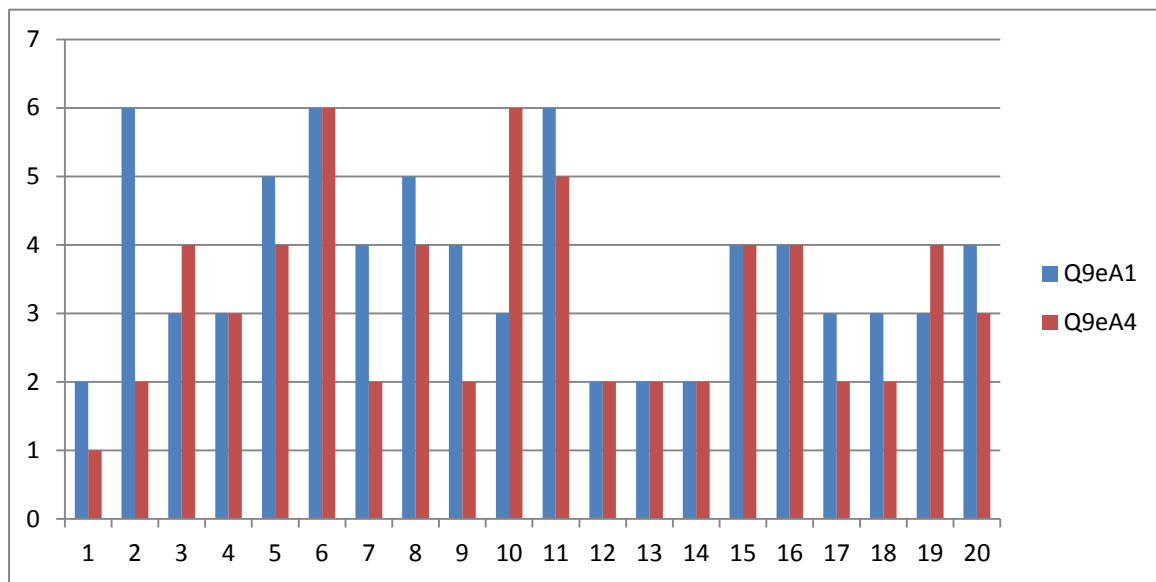


**Figure 23: Responses to question 3f of the SF-36 questionnaire at the first and final appointment**

Figure 23 shows that at the first appointment eight participants were 'not limited at all' in their ability to bend, kneel and stoop. The other participants were limited 'a little' or 'a

lot' in their ability to bend, kneel and stoop. At the fourth appointment the number of participants who reported that they were 'not limited at all' had risen to 12.

General well being was measured by several different questions in the SF-36 questionnaire. The questions asked were both negative and positive: 'Did you feel full of life?' and 'Did you feel worn out?' Question 9 asked participants to grade how they felt during the last four weeks on a scale of one to six, 1 representing 'all of the time', 2 'most', 3 'a good bit', 4 'some', 5 'a little', 6 'none of the time'. Question 9e, 'Did you have a lot of energy?' was selected as representative of general well being and also a relevant measure for homeopathy as an improvement in energy levels is one measure of a successful outcome of treatment.

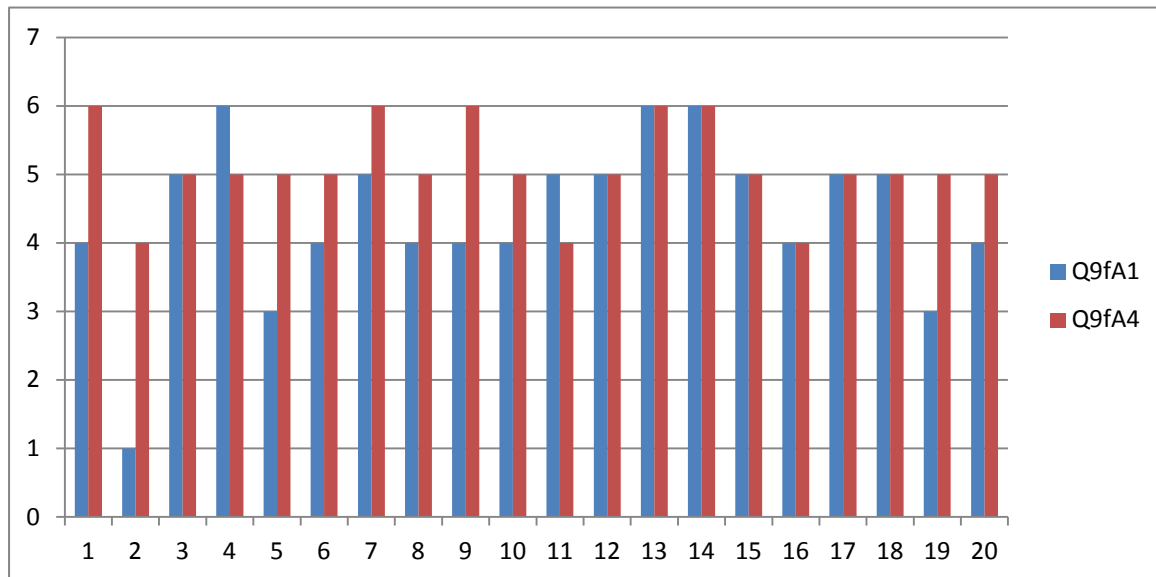


**Figure 24: Responses to question 9e of the SF-36 questionnaire at the first and final appointment**

Figure 24 shows that at the first appointment four participants said that they felt they had a lot of energy 'most of the time' and six participants said they had a lot of energy 'a good bit of the time'. By the fourth appointment, one person had a lot of energy 'all of the time' and eight had a lot of energy 'most of the time'.

### 3.7.2.3 Emotional well being

Emotional well being was also measured by question 9 in the SF-36 questionnaire. Question 9f asked respondents if they had felt downhearted and blue in the last month, on a scale from ‘all of the time’ to ‘none of the time’. Question 9 asked participants to grade how they felt during the last four weeks on a scale of one to six, 1 representing ‘all of the time’, 2 ‘most’, 3 ‘a good bit’, 4 ‘some’, 5 ‘a little’, 6 ‘none of the time’. The bar chart below shows the responses for all participants for the first and fourth appointment for question 9f.



**Figure 25: Responses to question 9f of the SF-36 questionnaire at the first and final appointment**

Figure 25 shows that 17 respondents in this study felt downhearted ‘none’ or ‘a little of the time’ at the final appointment, in contrast to ten at the first appointment.



### 3.7.2.4 Statistical analysis of data

The evidence from the descriptive data for the SF-36 questionnaire includes positive outcomes. It suggests that some participants believed that their health had improved. This improvement was indicated by an improvement in energy levels, emotional well being and a reduction in pain. This is a small study and therefore less likely to show statistically significant results or outcomes that can be generalised to the wider population, but it does show a positive trend in response to homeopathic treatment. Because of these positive outcomes, further statistical analysis was attempted, initially using graphs and scatter diagrams to plot changes for individuals and the study cohort over time and then using cross tabulation and Chi-Square tests. Initial reviews of this data seemed positive but further examination by a statistician confirmed that there was no evidence of statistical significance. Examples of this analysis are provided in Appendix 17.

The following tables summarise the changes in scores for PCS and MCS for all participants. Results from other research measures are again included for comparison.

### 3.7.3 Summary of outcomes including SF-36 questionnaire

Table 20: P1-10, summary of selected outcomes from the SF-36 questionnaire

	Participant interviews	Participant case notes	Homeopath's perspective	MYMOP (better > or worse <)	SF-36 PCS	SF-36 MCS
1	"definitely made me much calmer, I'm not so anxious" (L 73)	Better physically and emotionally	Better physically and emotionally	Symptom 2 better 5 > 0	52.50 > 54.90	28.30 > 62.70
2	"I wasn't allowed to take a remedy" (L 30)	Improving using anti depressants and self care	Better emotionally	Symptom 2 better 5 > 2	67.50 < 62.50	2.10 > 26.90
3	"I coped better" (L 51)	Better physically and emotionally	Better physically and emotionally	Improved well being 4 >1	41.30 > 57.50	57.10 < 38.90
4	"It really worked for me almost right away" (L 38 )	Better physically	Better physically	Symptom 1 better 3 > 1	47.50 > 52.90	60.80 < 49.40
5	"overall I've made definite progress" (L 48)	Better emotionally	Better emotionally	No change	40.80 < 38.60	39.00 > 61.90
6	"the first remedy it was good, it had a positive effect in the house" (L 50)	Improvement in mood, sleep, energy	Improving but not better	Symptom 1 better 6 > 3	25.20 > 31.80	42.90 < 27.50
7	"incredible, what an improvement" (L 55)	Better physically and emotionally	Better physically and emotionally	No change	45.80 > 50.20	48.00 > 61.80
8	"took away my headaches" (L 41)	Improvement in headaches on first remedy.	Improvement in headaches on first remedy.	Symptom 1 worse 2 < 4	29.30 < 24.50	54.90 > 59.60
9	"back to a greater sense of commitment to life" (L 63)	Better physically and emotionally	Better physically and emotionally	Symptom 2 better 5 > 2	47.10 > 59.50	29.90 > 48.40
10	"my back is a huge lot better" (L 48)	Better physically	Better physically	Symptom1 better 3 > 1	39.10 > 58.00	59.10 < 35.40

**Table 21: P11-20, summary of selected outcomes from the SF-36 questionnaire**

	<b>Participant interviews</b>	<b>Participant case notes</b>	<b>Homeopath's perspective</b>	<b>MYMOP (better &gt; or worse &lt;)</b>	<b>SF-36 PCS</b>	<b>SF-36 MCS</b>
11	"I'm more on an even keel now" (L 40)	Some improvement	Improving	Symptom 2 better 3 > 1	48.30 > 53.10	39.90 < 38.80
12	"Fascinating" (L 41)	Better physically and emotionally	Better physically and emotionally	Symptom 1 better 3 > 0	55.40 > 62.30	48.50 > 49.50
13	"arthritis was my thing in my wrists ....and it's certainly easier" (L 48-49)	Improvement in sleep and joint pain	Minor improvement	No change	55.50 < 55.10	56.70 < 50.80
14	"the general feeling of goodness and feeling well" (L 62)	Better emotionally, main physical symptom improved but not resolved	Better emotionally, main physical symptom improved but not resolved	No change	50.20 > 57.20	59.90 < 58.00
15	"I would like to have been able to report bigger changes" (L 125)	No change	No change	Symptom 2 better 3 > 2	59.30 < 56.30	41.60 > 50.30
16	"I have responded positively to the treatment" (L 57)	Better physically and emotionally	Better physically and emotionally	Symptom 2 better 4 > 1	38.00 > 47.20	41.50 > 51.70
17	"helped me to cope better" (L 38 )	Better emotionally	Better emotionally	Symptom 1 worse 1 < 2. well being better 3 > 2	48.70 < 47.20	54.60 > 55.40
18	"there's a healing taking place and it's fairly holistic" (L 38)	Better physically and emotionally	Better physically and emotionally	Symptom 2 better 3 > 1	47.80 < 47.30	57.70 > 60.30
19	"the positive effects came into force more gradually" (L 38)	Better physically and emotionally	Better physically and emotionally	Symptom 1 better 4 > 2	33.80 < 31.80	53.30 > 56.90
20	"a wonderful sensation, something is working" (L 55)	Better physically and emotionally	Better physically and emotionally	Symptoms better 5 > 1	54.30 > 57.50	31.20 > 52.50

### 3.8 OUTCOMES OF TREATMENT FOR INDIVIDUALS

The summary of outcomes from the research methods used in this study presented in tables 20 and 21, shows a strong similarity between the outcomes for each method used. The outcomes for individuals can also be grouped into categories of those who reported clear improvement, those who reported some improvement and those who reported little change in their condition. This is summarised in the table below.

**Table 22: Categories of outcomes for homeopathic treatment**

<b>Category of outcome:</b>	<b>Experienced by participants:</b>	<b>Number of participants:</b>
Improvement in all measures used in this study	P1, P7, P9, P12, P16, P20	6
Improvement in all measures except either PCS or MSC of the SF-36 questionnaire	P3, P4, P10, P18, P19	5
Improvement on four measures, including no change in MYMOP	P5, P13, P14	3
Some improvement, either generally or in one symptom	P6, P8, P11	3
Worsening of symptoms in MYMOP	P8, P17	2
No change on most measures but showed an improvement in MCS	P15	1
One person did not take the remedy, but reported improvement in three measures, including SF-36 and MCS	P2	1

For most participants in the study the outcomes reported were similar for the different measures used. There was also a strong connection between the quantitative and qualitative data, linking the more objective outcome measures for each individual and their story. Table 22 groups individuals into categories in terms of improvement in health and well being. Despite the connections between the outcomes for the different measures used in the study, links with the four key themes identified by participants in research interviews are less clear.

### **3.8.1 Perceived outcomes of treatment**

The first theme identified by participants related to perceived outcomes of treatment, including sub-themes relating to emotional well being, improvement in physical symptoms and commentary on ‘side effects’. There is a strong connection between those participants whose health is perceived to have improved on all measures and the language used in the interviews. Their view of improvement was expressed in language that was definite and clear about the positive outcomes of treatment. Noteworthy improvement in mood and well being, described by some participants as a feeling of joy and feeling really well, was not captured in the quantitative data. Descriptions of improvement in the ability to carry out physical tasks, such as putting on socks, or climbing stairs, were also not clearly reported for all participants in the quantitative data. Changes in mood relating to bereavement were evident in SF-36 data for the appointments closest to the experience.

### **3.8.2 The therapeutic relationship**

The second theme identified by participants was the therapeutic relationship, including sub-themes relating to honesty in telling their story and describing symptoms, the impact of reviewing life experiences, non-judgemental acceptance of their story and greater understanding of its meaning for them. Participants were divided about the value of the therapeutic relationship in improving health and wellbeing. For those participants who

showed improvement on all measures in the study, there was no consensus, some stating that it had no effect and others stating that it was an integral part of the homeopathic process. All participants valued the opportunity to talk to the homeopath and identified aspects of the relationship that facilitated openness. Similarly, the impact of telling their story was believed by many participants to be valuable but not necessarily a contributing factor to improvements in health and well being.

### **3.8.3 Beliefs about health and homeopathy**

The third theme related to beliefs about health and homeopathy, including knowledge of homeopathy, beliefs about health and healing, beliefs about reasons for changes in their health and the impact of being part of a research study. There was no evidence that participants who showed an improvement in health and well being on all measures believed in homeopathy or the placebo effect. Some participants in this category were very clear that their beliefs had no impact on the outcomes of treatment.

### **3.8.4 Aspects of the treatment process valued by participants**

The final theme related to aspects of the treatment process that were valued by participants, including the venue for treatment, the value placed on contact with the homeopath between appointments, the approach used in the homeopathic consultation and direct comparisons with conventional health care. All participants spoke positively of the venue, referring to the calm atmosphere, comfortable surroundings and professionalism of the setting. There was no evidence that contact with the homeopath between appointments made any difference to the outcome of treatment, although some participants found it reassuring. The participants who showed an improvement on all measures were again divided about the issue of contact and some were very clear that they did not make contact with the homeopath between appointments but experienced improvement in their health and well being.

Although connections between thematic analysis of interview data and outcomes of treatment is not clear, the strong connection between the quantitative and qualitative data, linking the more objective outcome measures and participants' stories was evident for individual participants. The following analysis of these connections between outcomes and narrative provides a more comprehensive view of individual experiences of treatment.

**Participants who showed definite improvement in all measures used in this study:**

- ❑ P1 showed improvement on all measures. Her account of her experience with homeopathic treatment was very positive for all research measures used. Minor changes in quantitative data reflected personal experiences such as bereavement which she described in the case notes for the equivalent appointment.
- ❑ P7 showed improvement on all measures and described the improvement in the interview, "It's just been incredible, what an improvement" (P7 L55). Although she retired from a job that she described as very stressful, a year before starting treatment, she still experienced symptoms that had been a problem when she was working. The only intervention that had made a difference to these symptoms was homeopathic treatment. She described her ability to carry out tasks such as gardening that would have exhausted her before, also the feeling of 'joy' and her ability to enjoy life without feeling under pressure.
- ❑ P9 showed improvement on all measures. She presented with an acute illness which was treated with a homeopathic remedy. She reported that symptoms were less of a problem and further symptoms did not develop. Underlying problems related to emotional well being and stress at work were also apparent and these were treated over the study period and she reported significant improvement.
- ❑ P12 showed improvement on all measures. Her initial symptoms related to a stressful life situation, but she seemed to be in good health generally. Her improvement was rapid and sustained and by the end of the study she reported that she felt something of a fraud coming for appointments.

- ❑ P16 showed improvement on all measures. His focus was on joint pain that prevented him carrying out tasks such as gardening and decreased his mobility generally. Although he spoke of trauma in the past and current stress, he did not acknowledge any emotional symptoms. The case notes suggested that there was an improvement in both physical and emotional symptoms and the more objective measure used in SF-36 showed an improvement in both physical and mental scores.
- ❑ P20 showed improvement on all measures. She suffered from severe and prolonged hot flushes. The remedy chosen was strongly indicated and had an immediate and progressive effect. She also described her improvement in very positive terms, “what benefits I’ve reaped from it, mainly cool and calm. You know I was hot and irritable, driving people nuts probably” (P20 L212-213).

There was no common link between these participants, either in initial health status, use of conventional medication or other treatments, or beliefs about health or treatment. In all cases the remedy seemed to be a clear match for the symptoms described and personality of the individual.

**Participants who showed definite improvement in all measures except either PCS or MSC of the SF-36 questionnaire:**

- ❑ P3 showed improvement on all measures except the MCS and this may be related to a bereavement experienced towards the end of the study. This change in emotional well being was apparent in quantitative and qualitative data.
- ❑ P4 showed improvement on all measures except the MCS and again this may be related to a sudden bereavement at the end of the study.
- ❑ P10 showed improvement on all measures except the MCS and again this may be related to a sudden bereavement at the end of the study. Her main physical symptom was reported to be better and there was some evidence of improved resilience as a result of taking the remedy.



- ❑ P18 showed a significant improvement as a result of the third remedy prescribed. He said that the remedy had ‘hit the spot’.
- ❑ P19 showed improvement on all measures but different aspects of her health improved with different remedies.

These cases illustrate the way that the results in this study reflect the life experiences of individuals. Almost a third of participants in this study suffered bereavement during the period of four to six months that they attended consultations. This may be related to the age group in the study which further supports the view that this can be a stressful time of life, involving significant losses.

#### **Participants who showed improvement on four measures and no change on MYMOP:**

- ❑ P5 showed improvement on most measures but she had difficulty at the beginning of the study with dental surgery under general anaesthetic which seemed to leave her weakened and traumatized by the hospital experience. There was a positive change in her emotional state towards the end of the study when she had recovered. This was an improvement on her emotional state before the dental treatment which was evidenced in both quantitative and qualitative data.
- ❑ P14 showed some improvement in the long term symptom he presented with, but reported definite improvements in well being, described as “the release, and then the general feeling of goodness and feeling well” (P14 L62).

These results again show the link between life experiences and evidence collected in the research measures. Problems with dental health were reported by several participants in the study. They were usually resolved with conventional dental treatment but individuals reported that this was a stressful experience and could lead to a general decline in well being. This is probably a typical experience of the 55+ age group but perhaps one that is underestimated in terms of health and well being.

These results also reflect improvements in mood that may be more difficult to measure. P14 described the improvement in mood in the interview and the case notes but this was not reflected in the quantitative data. This is discussed further in section 4.2.2 *Outcomes measured in homeopathic terms* and section 4.3.3 *The principles and process of homeopathic treatment*.

**Participants who experienced some improvement, either generally or in one symptom:**

- ❑ P6 showed initial improvement in well being but this did not continue. When the remedy was changed there was evidence of a homeopathic aggravation but no improvement. His symptoms may have been caused by long term use of pain killers and he eventually made the decision to reduce the use of painkillers which seemed to lead to some improvement. His symptoms seemed to start when his working life was difficult. This was followed by several bereavements in quick succession. The first remedy prescribed related to grief and loss, including the loss of his job and his perception of himself as someone who had a significant role in his employment and this may have accounted for greater success with the first prescription than with later remedies.
- ❑ P8 presented as flat in terms of mood and energy. The first remedy helped her headaches, which were a significant problem for her, but despite persisting with this remedy there was no further improvement. A change of remedy did not seem to make any difference although she reported feeling worse when she stopped taking the remedy on holiday. At the end of the study she developed a frozen shoulder, a recurring problem in her health history, which caused her a great deal of pain. This is a good example of the changing nature of health, particularly in this age group and the difficulty in prescribing remedies to match these changes.
- ❑ P11 showed signs of improvement on the second remedy and e-mailed after the study to say that she was feeling better. The first remedy prescribed was well indicated and had been prescribed for her successfully before by a homeopathic GP. It was very surprising that it did not have any effect. As both patient and

homeopath believed it would work, this case challenges the view that belief in a particular treatment has a positive impact on symptoms.

- ❑ P13 appeared to report little change overall during consultations but referred to improvement in specific symptoms. In the final research interview she described herself as ‘better’ and valued the process of treatment.

All these cases reflect the complex nature of health issues for the 55+ age group and the difficulty of clearly identifying a remedy that will be beneficial for the whole person. It also reflects the health history of individuals and the impact this has on treatment. Ongoing or previous treatment of health problems may impact on the ability to treat current symptoms. It is also more difficult when treating participants holistically to isolate causes of problems. A further complication is the requirement that homeopaths do not give advice on conventional medication. If there is to be any change in the use of medication this must be identified by the individual participant or their doctor.

### **Participants who experienced a worsening of symptoms in MYMOP:**

- ❑ P8 experienced pain from a frozen shoulder
- ❑ P17 experienced a very stressful time at work

The change in their physical health was very clear in the quantitative data. If a mixed methodology had not been used it would not have been possible to offer an explanation for this change. Both participants experienced these changes at the end of the study and in normal practice the treatment would have been ongoing, taking account of new symptoms and treating them as they occurred.

**Participant who experienced no change on most measures but an improvement in MCS:**

- ❑ P15 expressed disappointment that she had not responded to any of the remedies taken. She said that she enjoyed the consultations. Her final score for the MYMOP well being question showed an improvement in her perception of how she felt. There was no obvious reason for this in her case notes or her interview transcript.

**Participant who did not take the remedy, but showed improvement on some measures:**

- ❑ P2 did not take the homeopathic remedy. She chose to remain in the study and experienced all other aspects of treatment. The improvement in her health seemed to be related to anti-depressant medication. She said that this had relieved symptoms but although she was able to do all the things that she used to do, she did not feel the way she used to feel. She made use of self care methods discussed in the consultations and felt that these strategies helped her recovery.

Based on the outcomes for the different research methods in this study, there is evidence that the perceived health and well being of most of the participants improved. Ten participants seemed to show definite improvement on almost all measures. Eight participants showed improvement for specific measures or symptoms. One participant showed no general improvement and one participant improved but did not take the homeopathic remedy.



## CHAPTER 4: DISCUSSION

### 4.1 INTRODUCTION

The evidence in section 3 *Results* suggests that most participants in this study experienced an improvement in health and well being over the period of time that they received homeopathic treatment. The purpose of this discussion section is to consider whether this evidence provides a clear answer to the research questions:

- ❑ Is homeopathy perceived to be effective in improving health and well being and quality of life in the 55+ age group?
- ❑ What are the common themes in the experience of homeopathic treatment described by participants in this study?

Discussion of these questions focuses on the outcomes of treatment, common themes in the research evidence and analysis of the methodology used to collect the research data.

Both questions involve consideration of the health needs of the 55+ age group and whether it was homeopathy that was responsible for any change in health in the individuals in this study cohort. The second research question also raises the issue of how homeopathic treatment was experienced by the individuals taking part in this study and whether there were common themes in their accounts of treatment. It is also important to consider whether the measures used to evaluate health changes in this study gave an accurate picture of what happened. By linking the evidence with the literature on the subject of health, homeopathy and healing, it is also possible to consider whether the results in this study are supported by the findings of other research into homeopathy and published accounts of the philosophy of classical homeopathy.

## **4.2 OUTCOMES OF HOMEOPATHIC TREATMENT IN THIS STUDY**

For the purposes of this research study homeopathic treatment was defined as a complex intervention, taking into account the use of the homeopathic remedy, self care and the therapeutic relationship. Boon et al (2007) refer to the difficulty of defining the active ingredients of a complex intervention. It can also be more difficult to evidence outcomes of homeopathic treatment as it is a holistic and individualised approach to health care. The chosen population for this study is also diverse in age, life experiences and health issues. The research questions require the measurement of perceptions of healing and this inevitably includes subjective responses which may be difficult to generalise across the study cohort and to the wider 55+ population.

In order to evaluate the outcomes of such a complex intervention as comprehensively as possible both qualitative and quantitative data was used to record outcomes. Five research measures were used: interviews with participants, case notes, the practitioner's reflective journal, MYMOP and SF-36 questionnaires. These measures have been used to record the outcomes for the study cohort and for individuals. They also show the connections between individual responses in each of the measures used and the links between individual life experiences and the responses they gave in interviews and questionnaires.

Although it is not possible to make direct comparisons with other studies of homeopathy as a complex intervention, or homeopathy for the 55+ age group, there are some studies which have connections with the research questions for this study and they are considered in this discussion. Consideration is also given to the homeopathic view of outcomes as it relates to this study.

### **4.2.1 Outcomes compared with other studies of homeopathy**

The positive outcomes for this study are similar to those for some other studies of homeopathy, despite differences in methodology and the focus on the 55+ age group. Similar outcomes are found in studies of the general population for a range of presenting symptoms and also studies of specific symptoms treated with homeopathy. There are also connections with research providing evidence of homeopathy improving well being and quality of life.

In this study, ten participants out of twenty reported definite improvement on almost all measures and six participants showed improvement on most measures or for specific symptoms. Two participants reported limited response to homeopathic treatment. Positive outcomes from homeopathic treatment for about 70% of the study cohort are reported by the Bristol study (Spence et al), the Tunbridge Wells Homeopathic Hospital in 2000 (Clover 2000) where 74% of 1372 patients reported a positive result from homeopathic treatment, and the Liverpool Department of Homeopathic Medicine (Richardson 2001), where 76% of 1100 patients also reported an improvement in their condition. The typical placebo effect is thought to affect about a third of any study population (Di Blasi 2005) so all of these studies suggest a positive treatment effect beyond that which can be attributed to placebo. The comparison between large hospital based studies and a single practitioner study of 20 participants is not a comparison of like with like, but the similarity between the percentage of participants in all the studies whose health improved is noteworthy.

Research into the treatment of specific symptoms or diseases using homeopathy also provides useful comparisons with this study. The most frequent presenting symptom in this study was joint pain. This is common in the 55+ age group and leads to significant limitations on mobility and the ability to carry out daily tasks or hobbies that give pleasure. Shealy et al (1998) treated 65 sufferers of osteoarthritis in a double blinding process. Participants were given either a homeopathic remedy or Acetaminophen, a



commonly prescribed drug for pain relief in osteoarthritis. In this trial homeopathy provided greater pain relief than Acetaminophen, and there were no adverse reactions. As this is a common problem in the 55+ age group, any alternative treatment method, such as homeopathy, that can have a positive effect on joint pain is worthy of further consideration. It is also potentially valuable in terms of the cost of treating patients with conventional medication. Swayne (1992) and Christie et al (1996) reported on the cost effectiveness of homeopathy. Milton (2008) refers to government statistics which show that the 60+ age group receive 59% of prescribed medicines but make up only a fifth of the UK population. Witt et al (2008) also considered the longer term effects of homeopathic treatment for sufferers of chronic ill health in a long term observational study. Their results suggest that positive treatment effects persist for as long as eight years. All these studies support the view that homeopathy is a potentially valuable treatment for joint pain in older people. Participants in this study who experienced joint pain described noticeable improvements in pain and mobility after homeopathic treatment.

Participants in this study who suffered from emotional health problems also reported improvement in symptoms. This type of improvement is reflected in a study by Dempster et al (1998) in which 81% of participants said that they were very satisfied with homeopathic treatment. This was a small study involving only 37 participants with common mental health problems but it is supportive of the view that homeopathy is helpful in improving emotional well being.

In this study, participants reported on the wider benefits of homeopathic treatment, not just symptom relief. This was also reported in an evaluation of the use of CAM in two primary care centres in Northern Ireland (McDade 2008). Researchers reported an improvement in physical health in 81% of participants (713 participants took part) and 79% in their mental health. Participants who received homeopathic treatment reported an average 54% improvement in their health and well being. The use of mixed methodology to capture different perspectives on the outcomes is also relevant to this study. In both

cases it was possible to record additional benefits of treatment beyond those recorded in MYMOP, which are largely symptom based. In this study, participants also referred to improvements in well being, in terms of feeling calmer and having the ability to enjoy life once more.

Several studies of homeopathy have highlighted the need for alternatives to conventional treatment. A study on menopausal symptoms by Relton (2009) highlighted the need for alternative treatment for women who were unable or unwilling to use the conventional treatment of hormone replacement therapy. One participant in this study benefited greatly from homeopathy for hot flushes, having found other forms of treatment unsatisfactory. Sevar (2000) also carried out an audit of outcomes in 829 consecutive patients treated with homeopathic medicines because conventional treatment had been unsatisfactory or contraindicated and found that 61 % showed a noticeable improvement after homeopathic treatment. In this study, some participants reported a desire to cut down or avoid conventional medical treatment for selected health problems. In the 55+ age group, where the use of pharmaceutical medicine is more common, the availability of a cost effective alternative with fewer side effects is likely to be of great benefit to some individuals.

Participants in this study had experienced symptoms for varying lengths of time but most had tried different treatments without success over a period of years. Improvement in their symptoms and well being achieved with homeopathy was similar to improvements reported by Sevar (2000). Homeopathy may be seen as a last resort by some users when all else has failed, but studies like this suggest that it could be a valuable option much earlier in the treatment process.

Most studies of homeopathic treatment focus on specific symptoms or diseases and use RCT's to test homeopathic remedies as if they were pharmaceutical medicines. An example of this is the study carried out by Haidvogel et al (2007) to compare the use of homeopathy and conventional treatment in acute respiratory and ear complaints. The main conclusion was that the onset of improvement was faster in both adults and children

receiving homeopathic treatment. The research by Haidvogel et al (2007) provides a direct contrast to the approach used in this study. The focus of their study is an acute illness and the comparison is with conventional treatment. It is also interesting to note that the authors themselves commented on the limitations of their approach specifically the use of standardised protocols rather than the 'real world' approach favoured by the Bristol study (2005).

Researching homeopathy as a complex intervention using a mixed methodology takes account of the complexity of health issues in older people. In contrast, research that reduces patient experience to symptom relief denies a significant part of their life and health history. Many participants in this study referred to the connections made during the study between past experiences and present health issues. Their ability to make these connections and to gain enlightenment in the process was part of what several of them described as the 'journey' experienced during homeopathic treatment. This was found to be a valuable experience for participants in this study and may be important for the wider 55+ population, and for health care provision for future generations of older people.

The research study that is most closely linked to this study was carried out by Teut et al (2010) into the use of homeopathic treatment in elderly patients. Although the study population was older, all aged over 70, the outcomes were measured using a numeric rating by patients for the severity of symptoms and SF-36 for quality of life. The severity of complaints decreased significantly over the 24 months of treatment. Unlike this study, the quality of life and number of medicines taken did not change significantly but remained stable. It is possible that the life and health experiences of people over the age of 70 are different from those in the 55 – 70 age group, who took part in this study. The studies on long lived people (Larkin 1999) suggest that the potential for living a healthy life into old age is greater than might be expected. The outcomes of this study suggest that it would be useful to consider the part homeopathy has to play in this process, particularly if treatment is available before the age of 70.

Homeopathy is included in some research studies on several CAM therapies, but results suggest positive outcomes for both CAM and homeopathy. Richardson (1996) carried out a study of homeopathy, acupuncture and osteopathy and reported that 89% of participants experienced positive effects from these treatments. He commented particularly on the improvement in vitality, ability to function socially and improved ability to carry out daily tasks. Homeopathy was regarded as particularly useful for sufferers of arthritis. Richardson's findings reflect some of the evidence provided by participants in this study, particularly the improvement in mood and energy and increased mobility. The ability to enjoy life and return to former pursuits also has implications for society as individuals are able to play their part as productive citizens rather than depending on others.

Overall, the outcomes for this study reflect similar outcomes to other research into the effectiveness of homeopathic treatment. Although this study focuses on a specific age group and identifies homeopathy as a complex intervention, there is evidence that other research studies using different approaches achieve similar outcomes. Some of these studies also make reference to the wider benefits experienced by participants receiving homeopathic treatment which link with the philosophy of classical homeopathy considered in the following section.

#### **4.2.2 Outcomes measured in homeopathic terms**

“In patients from all walks of life, I have witnessed the transformation of consciousness, from suffering and disease to freedom, vitality and happiness.”  
(Chappell 1994: 232)

Creswell (2009) believes that making connections between broader existing theories and qualitative data on individual experiences increases the validity of the results and the potential for generalising them to a wider population. Outcomes from each of the different research methods have been discussed in relation to the effectiveness of homeopathic treatment in promoting health and well being in the 55+ age group and connections made with existing research. The outcomes of treatment can also be

evaluated in terms of their connections to defined homeopathic principles and philosophy.

The aims of classical homeopathic treatment are based on Hahnemann's philosophy outlined in his *Organon of Medicine* (1810). These are:

- ❑ to relieve suffering and improve identified symptoms
- ❑ to promote well being
- ❑ to improve energy levels and motivation
- ❑ to restore emotional calm
- ❑ to foster the ability to cope with change and difficulties
- ❑ to be at ease with self and with others
- ❑ to be creative in whatever way the individual identifies creativity

These aims go beyond the relief of symptoms. Curtice and Trotter (1999) note that a healthy person shows spontaneity and ease in the way they respond to new challenges in life. Featherstone and Forsyth (1999) also define health as the ability to respond to situations in a way that increases a sense of autonomy, spontaneity and joy. The definition of health provided by the World Health Organisation (1948) also refers to complete physical, mental and social well-being and not merely the absence of disease.

Chappell (1994) lists ten signs of cure as a result of homeopathic treatment and there is a strong link with the items he lists and the experiences of participants in this study. His list is also directly linked to the philosophy of classical homeopathy. Table 23 lists his ten signs of cure and also the participants in this study who reported experiencing these signs.

**Table 23: Chappell's ten signs of homeopathic cure (1994)**

<b>Chappell's ten signs of homeopathic cure (1994)</b>		
1	Feeling better in yourself and more confident	Reported by: P1, P3, P5, P7, P9, P10, P11, P12, P14, P16, P17, P18, P19, P20
2	Being able to deal with life more effectively	Reported by: P1, P3, P5, P7, P9, P10, P11, P12, P14, P16, P17, P18, P19, P20
3	Having more energy	Reported by: P1, P5, P7, P9, P10, P12, P14, P16, P18, P19, P20
4	Changing aspects of your life for the better	Reported by: P1, P20
5	Becoming more creative	Reported by: P18
6	An emotional or physical aggravation of symptoms, often based on elimination of toxins and evident in sneezing, colds, boils, fever etc	Reported by: P4, P6, P14
7	A brief return of old symptoms	Reported by P5, P6, P17
8	Physical symptoms just get better	Reported by: P3, P5, P7, P10, P12, P16, P20
9	An experience of dreaming of past experiences which has a positive effect	Not reported by any participants in this study
10	Initially feeling better in yourself and then physical symptoms improving	Reported by P6, P7, P14, P17, P19

The evidence in this study suggests that participants responded to homeopathic treatment in accordance with the principles of classical homeopathy and Chappell's ten signs of homeopathic cure (1994). These principles may also be relevant to other therapeutic interventions but their importance here is that the outcomes were not random but were part of a defined homeopathic process which can be replicated. This process is explored

further as one of the common themes in the treatment process in section 4.3.3 *The principles and process of homeopathic treatment*.

Participants in this study reported both physical and emotional outcomes of treatment that were unexpected by them and went beyond the symptom relief that they might have expected. These experiences also link with Chappell's ten signs of homeopathic cure (1994). The physical symptoms included: improvement in symptoms that had not been reported in the consultations, improvement in a symptom that was only a problem on holiday, symptoms such as severe sneezing followed by improvement in the main symptom, skin and eye symptoms that improved unexpectedly and changes that for them reflected an improvement in health such as hair curling. Emotional symptoms that surprised participants included expressing emotion through tears, talking about past events and improvement in relationships with others. (See *Table 7: Surprising reactions to homeopathic remedy identified by participants*) These surprising experiences are just part of the picture of homeopathic outcomes, but they illustrate outcomes of treatment that go beyond improvement in identified symptoms.

The responses to interview questions also revealed outcomes for individuals that cannot be easily measured, but seemed to be important to them and give an indication of the type of health care that these individuals, and perhaps the 55+ age group are likely to value. References to self realization, resilience, being cared for and ontological changes in perception were apparent in evidence from participants. These changes reflect Hahnemann's aims for cure and Chappell's ten signs of homeopathic cure (1994).

These changes in understanding and being are also described in the literature on health and healing. Millenson (1995) believes that by looking for meaning in the patient's narrative we get a prognosis for the disease, and hope and empowerment for the sufferer through greater understanding of life's disharmonies. Capra (2005) also sees ill health as an opportunity for introspection. Several participants in this study referred to the experience of homeopathic treatment as a journey and others spoke of it as an

enlightening experience. One participant referred to this in detail in his interview responses.

“It involved in particular almost a cleansing of your soul and certainly a telling of your story which I hadn’t appreciated would form as big a part of what was done.  
(P14 L31-32) ...it was quite liberating and has remained quite liberating in terms of it has allowed me to reflect on where I’ve come from and what I’ve done and to an extent how I’ve got to be maybe the personality and the person that I am”  
(P14 L36-38)

Murray (2008) describes narrative as the human means of making sense of a changing world and a way for individuals to bring a sense of order in a disordered world. Participants in this study seemed to value the opportunity to review the past and make connections between life experiences.

Launsø (2008) refers to three categories of treatment results including those related to bodily sensations such as more energy and better sleep. His other two categories include changes in awareness and insight, including changes in understanding of the illness, and changes in the ability to manage illness or handle life situations. It is apparent in this study that some participants experienced changes relating to awareness and insight, particularly about their past and their view of others who had caused them emotional pain.

Launsø’s (2008) third category, the ability to manage illness or handle life situations was also apparent in this study. Some participants spoke of increased ability to cope with the pressures in their lives, an increased resilience reflected in greater self awareness and potentially greater assertiveness and more control in difficult situations.

This greater resilience may be very important to the 55+ age group who often experience the pressures of work and family at the same time as they experience changes relating to ageing. This was particularly true for some participants in this study who were part of a four generation family and had a caring role for both parents and grandchildren. Others in



the study who were still in employment, found the workplace and relationships with colleagues and those in authority difficult. They required greater resilience to manage the challenges involved in working life. Larkin (1999) refers to resilience as a characteristic of long lived people. Resilience, like self realisation is not easy to measure.

Participants in this study referred to a feeling of being themselves again, as if they had rediscovered the person that they used to be. The evidence of this change is usually a more balanced and relaxed approach to life, which includes openness to different ways of relating to others and an acceptance of issues that might have been regarded as stressful in the past. There can also be evidence of increased energy levels and creativity, leading to a feeling of being more productive, seeing issues more clearly and managing tasks easily. Many participants spoke of this type of experience in different ways.

A common symptom of being unwell is feeling impatient or irritated with others, particularly family and partners. There was evidence in this study that participants who felt better also managed relationships more successfully and found that they were less annoyed by others and more at ease with those close to them. This often led to a more relaxed relationship as the partner responded to the changed behaviour.

These changes in perception could be very important for people in the 55+ age group, offering new ways of seeing past and present experiences that are less hurtful or harmful and promoting more positive relationships.

### **4.2.3 Outcomes and the homeopathic process**

Milgrom (2003) describes in some detail his theory of entanglement, attempting to define the complexity of the homeopathic process which involves not just the homeopathic remedy but human interaction and the context for treatment. MacEoin (2006) believes that homeopathy has never been tested as it really exists because the focus has been on the remedy or the symptoms of disease rather than the complexity of the process,

involving different remedies, different potencies and periods of waiting for a healing reaction. The complexity described by these authors was apparent in this study, acknowledged by the participants and the homeopath and recorded in the qualitative data.

Participants in the study were asked what part of the homeopathic treatment process made most difference to their health and well being. Although most participants were clear that the remedy made a difference, they also referred to the importance of the process. Much of the research on homeopathy has focused on the remedy reaction and attempted to replicate research used for pharmacological trials. The approach taken in this study was to consider homeopathy as a complex intervention. Despite this approach it was clear from the case notes and participants' commentary that the homeopathic remedy did have a dynamic effect on individuals in the study. This was evident in the outcomes of treatment which were different from other types of treatment used before by participants, but more importantly were closely associated with homeopathic theory and philosophy. This may appear to endorse the remedy as the healing agent, but the process that leads to the selection of the remedy was also valued and without this process there is no remedy choice. The more accurately symptoms are described, the more likely it is that the homeopath will select the remedy that is most closely associated with these symptoms.

The description of symptoms in the 55+ age group is complex and closely linked with life experiences and individual perceptions of what has happened to them in the past. The process of reviewing this in order to select the remedy may also be an important part of the healing process. The themes revealed by the participants in the research interviews, identified different perspectives on the same topic. Some participants believed that the therapeutic relationship with the homeopath was a factor in improvements in their health and others believed it was 'nice' but did not make a difference to their health. Two participants supported the theories of Milgrom (2003) and MacEoin (2006) stating that the remedy and the process could not be separated.

In summary, it seems that the remedy did have a dynamic effect, but this was based on the complexity of the homeopathic process not separate from it. Homeopathy for the 55+ age group is a complex intervention. Attempts to identify the key component in the treatment process devalue the complexity of life experiences for this age group and the complexity of the homeopathic treatment process.

### **4.3 COMMON THEMES IN THIS STUDY**

This discussion explores common themes and participant experiences in this study. It makes connections between the participant experiences that were common in this study and the literature on the 55+ age group, health and healing, and homeopathic philosophy and practice.

#### **4.3.1 Health care needs of the 55+ age group and the study cohort**

Major concerns have been expressed about the health related issues of an ageing population and the use of drugs in treating chronic health problems (Macdonald et al for the Faculty of Actuaries 2006, Smallwood Report 2005). The aim of this study was to consider whether homeopathy could be effective in improving perceived health and well being for the 55+ age group. This age group is more likely to suffer from health problems that require treatment (Macdonald et al 2006). Barker et al refer to “the complex and multifaceted nature of the aging experience” (2007: 3) which makes it more difficult to research health interventions for older people.

Researching older people inevitably means defining what is meant by an older person. Chronological age provides the most frequently used defining characteristic for this section of the population, although other means such as being retired from paid employment and physical functioning are also used. The turning point for individuals in defining themselves as older people often comes at a certain birthday, or when they retire from work or when they develop an illness or disability that makes them less able to carry out normal activities or increases their dependence on others. This turning point is frequently after the age of 50 and for that reason the age of 55+ was chosen for this study as a common point where people might begin to consider that they are older. The definitions of ageing are inevitably inadequate and the literature on ageing suggests that older people represent as diverse a group as any other age group in the population.

Individuals have different views about their age related status and adopt different behaviours to confirm or challenge physical ageing. This was certainly true of the people who took part in this study.

Participants in this study were aged between 55 and 70 years of age. This included people in employment, people who were retired and those who were working in the voluntary sector. One person was signed off work when she began homeopathic treatment but returned to work before the end of the study. Another person had retired as a result of ill health and although he had a hobby that was very important to him, his ability to take part in it was limited by his health problems. All other participants continued their daily activities despite the health condition that led them to participate in the study.

Just as the diversity of the general population is represented in the 55+ age group, so are the health issues, but most illnesses are more prevalent as people get older and some illnesses are generally more common in the older population, particularly chronic illnesses which do not always respond well to conventional treatment. Beaglehole et al (2007) refer to chronic diseases as a leading cause of death and disability with profound economic effects. Patients rarely have one health problem, and this is particularly true for older people (Greenhalgh et al 2000). In this study there was evidence of different health problems, but what was more obvious was that the health issues were not always clearly defined by the participants. Although participants were asked what symptoms they hoped to resolve using homeopathy and also identified symptoms on the MYMOP questionnaire, they were not always open or clear about what they felt was wrong. This was expressed in the following way by one participant:

“It’s just been incredible, what an improvement, but also you know, the elephant in the room, the thing that I never even thought to talk to you about was how tired I was.” (P7 L55-56)

Participants often preferred to talk about physical symptoms and mention emotional pain as an afterthought or by product of physical health issues. If this is typical of the age group, then this is an important consideration for current health care provision. The

duality of current health care, which separates physical and mental health issues, may be particularly problematic for the 55+ age group. Mitchell and Cormack (2005) refer to the “bodily expression of psychological stress” which leads to lots of tests for physical causes of illness. They suggest that between a quarter and half of medical patients have no physical cause for symptoms, but suffer from anxiety or depression. The opposite was also found to be true. Patients receiving psychiatric treatment often failed to receive treatment for physical health problems. This dualistic thinking in conventional health care leads to neglect of important health issues, but a holistic approach to health problems can mean that all important symptoms are acknowledged.

Some participants referred to a process of ‘enlightenment’ which they experienced during the study and this seemed to be related to making connections between health, emotions and individual responses to life events. One participant stated on her MYMOP questionnaire that her main symptom was hip pain. She later said that she did not expect this to be resolved with homeopathy but she put it on the form as an acceptable answer to the question. The real issue for her was lack of energy and motivation and often extreme sadness. She was not the only participant who reached this kind of conclusion in the study. Some participants expressed a deep sense of loss that they were without a partner in life. The thought of facing old age alone caused them distress. Sadness was expressed about past losses, such as the loss of a baby 30 years ago, or the loss of a mother who was described as a best friend. These were not issues that homeopathy could change, but the resulting sadness, guilt or loneliness might be relieved if improved emotional well being was the outcome of homeopathic treatment. It may be that part of the ageing process is about grieving for losses and coping with the fact that some things that are very important to the individual may never happen. A key feature of wellness for older people may be greater acceptance of change, or energy and motivation to manage change. In this study the homeopathic treatment process was seen to have value in promoting this improvement in well being.

The 55+ age group does have one factor in common and that is that they are survivors. They have not succumbed to accident or fatal illness. This does not ensure good health but it does suggest some resilience and ability to manage health issues. In this study, this was particularly true. Participants had overcome serious illness, war, bereavement, divorce, redundancy at work as well as the common age related experiences of children leaving home and changes in working life. Despite the sadness in many of the stories told, there was frequently a positive acknowledgement of the good things in individuals' lives, including work of a paid or voluntary nature, travel, family, friendship and busy lives. One participant described significant traumas in her life, but valued her partner and the life they lived together which included adventurous travel and shared interests. Her present life, however, was clouded by anxiety and a preoccupation with past traumas which had only developed in recent years. She described herself as "annoyed" that these thoughts prevented her from enjoying life. This example highlights the common theme in the case notes of individual participants that ill health of whatever nature, spoilt the good things that they wanted to enjoy at this stage in their lives.

There was also evidence in this study that survivors survive because of mental attitudes that help at traumatic times but may have disadvantages. The common expression 'you just have to get on with it' was spoken frequently in consultations. This 'grin and bear it' philosophy may be typical of the post war generation who took part in this study. It may also be typical of the Scottish or British personality and culture that values stoicism (Williams 1983, Capro 2005). In this study, there was evidence that it had served a purpose but may also have been responsible for undermining health and preventing individuals from giving themselves the level of care that was needed.

In this study there were strong associations between life experiences and health problems. Some people in the 55+ age group find that life is more leisurely and they are better off financially and have fewer responsibilities. For others in this age group, it may be a time of great stress as a result of bereavement, loss of livelihood, becoming a carer, changing home environment or considering themselves less valued in the workplace and society

generally. These experiences were all reflected in the commentary of the participants in this study. Six participants experienced bereavement during the study, including two participants whose mothers died. Two participants had significant roles in caring for elderly parents. Those who were working reflected frequently on the stress associated with responsibility for budgets and staff, working long hours or working with difficult people. One participant suffered significant workplace bullying in a setting that might have been expected to be more caring. All these experiences had an impact on well being and this was reflected in responses to the questionnaires used to measure outcomes of the study as well as in the case notes used to develop a treatment plan.

The 55+ age group have the potential to live fulfilling lives and to contribute to the well being of others in society. This potential may be limited by chronic health problems, which may be exacerbated by lack of acknowledgement of the wider factors associated with the more easily identifiable symptoms. Treatment which is holistic in nature offers an opportunity to consider the needs of the whole person, taking account of past and present burdens, and offering the individual the opportunity to see more clearly what is needed to promote their well being. This type of holistic health care seems to be a valuable resource for the 55+ age group particularly. In this study, it was clear that the participants in the 55+ age group valued specific aspects of the homeopathic treatment process, including:

- ❑ the opportunity to tell their story and be heard, to revisit past experiences and gain new insights
- ❑ spending time in a calm, professional atmosphere focusing on what was important to them
- ❑ revisiting past experiences and considering how they impact on the present or how that impact can be reduced
- ❑ but most importantly valuing the improvement in their health and well being which offered a new opportunity to get on with their lives without the limitations associated with their health problems



These benefits seem very important for individuals but are also valuable for society, allowing older people to live more productive lives, contributing to the wider community rather than depending on it.

#### **4.3.2 Causation of health problems in the 55+ age group and the study cohort**

“Patients and physicians have begun to realize the value of elements such as faith, hope and compassion in the healing process.” (WHO 1998: 7)

Owen (2008) describes causation of illness as multifactorial. He believes that a patient’s cultural, social, familial and physical environment mirror each other. Implicit in this is a tendency for individuals to repeat certain patterns of behaviour.

Herzlich and Pierret (1986) note that lay people usually take a variety of factors into account when looking for the cause of illness, including climate, working conditions, bereavement and other factors and do not simply accept that ill health is caused by pathogens or disease processes. This was certainly true in this study and influenced both outcomes and thematic analysis of the process of treatment.

An important part of homeopathic treatment is the process of assessing the nature and cause of illness and the time when symptoms began. This often establishes a connection between life events and health issues. The analysis of homeopathic case notes includes taking account of the apparent causation of ill health. This analysis is carried out in a structured way, according to the principles of classical homeopathy, and leads to the selection of the most appropriate remedy for the individual. The analysis of case notes in this study indicated a strong connection between perceptions of life experiences and health issues.

Vithoulkas (1979) defines illness as a derangement of the life force of an individual. The susceptibility of individuals determines the nature of the illness to which they succumb.

He refers to scientific research which shows the connection between emotions and physical reactions, such as fear producing a dry mouth and perspiration.

“Every stimulus, every emotion, and every thought has a corresponding effect to some degree on all levels of the body simultaneously and instantaneously.”  
Vithoulkas (1980: 49)

Chappell (1994) describes the impact of feelings on health. He describes our natural state as zestful, open to challenges, affectionate and cooperative with others. In his view, when feelings are hurt, flexible human intelligence stops processing and responding appropriately. The repetition of inappropriate responses leads to a malfunction pattern which becomes part of an individual's chemistry and attitudes, and is the precursor of disease. He sees homeopathic remedies as maps of all known human malfunctions, capable of releasing this pattern of malfunction, often producing a toxic elimination process common after taking homeopathic remedies. He refers to the current medical model as seeing illness as something that ‘just happens’. Individuals in this study spoke of the reductionist approach to health issues which had failed to resolve their health problems. In contrast they found that the homeopathic approach increased their awareness of the connections between their responses to life experiences and health issues.

Kent (1900) also believed that sickness is caused from within man, not from bacteria or other external causes. Chappell (1994) explores this theory in more detail and refers to the way overwhelming experiences are commonly buried in the tissues and cells of our bodies, but surface later on as memories or ill health and require a healing intervention. Healing may be made more difficult if an individual is in a state of denial, seeing symptoms as bad luck rather than related to something in the past. He believes that treating symptoms with drugs is ‘papering over the cracks’ and may turn a past trauma into a more serious disease. He believes that old traumas condition and restrict our response to current experiences. Individual participants in this study spoke of experiences in their lives that had been suppressed. They valued the opportunity to speak about what had happened to them and make connections between past experiences and their present

state. They also valued the opportunity to go back to past events that were no longer part of their regular conversation with others and reflect on the emotions felt and the importance of what had happened to them.

The evidence in the case notes for participants in this study suggests that beliefs about the causation of health issues were very different for each individual but reflected the views of Kent (1990) and Chappell (1994). Participants linked current health issues to their upbringing, past trauma, personality, stress, the behaviour of others and random associations with life events and experiences. Thompson (1999) refers to the unique story of the patient that may be unheard in other health care settings, which offers connections between significant life events and health problems.

Most participants spoke about their upbringing and their families. They were asked about health during different stages of their lives, about health issues in their family, and also about significant turning points in their lives. These questions often produced an account of their early life and the significance of that time for them. In some cases there were links between well being in later life and patterns of behaviour that might have contributed to ill health.

Trauma and the memory of traumatic experiences seemed to have a significant effect on the health and well being of some participants. For others, experiences that might be regarded as traumatic or distressing were not presented in that way by the participant. Incidents that might seem unimportant, or even the apparently well intentioned behaviour of others caused significant distress to some participants.

Most participants had tried other treatments for their condition before trying homeopathy or had experience of NHS treatment for other conditions. The experience of health treatment was often memorable and sometimes traumatic. In describing what was positive about homeopathic treatment, participants often made comparisons with conventional health care, suggesting that it was unsatisfactory. There was often an initial

expression of faith and hope in conventional treatment and surprise and disappointment when treatment was unsuccessful or had other distressing outcomes. The change in perception resulting from this was often a factor in seeking homeopathic treatment. In some cases there was praise and gratitude for life saving conventional treatment. Some participants had struggled to avoid conventional treatment, for example for thyroid problems and a hip replacement operation. For them the change in perception was that self care and complementary treatments were unable to help them. These perceptions were part of the individual health profile and life experience which had an ongoing impact on their well being.

The cause of symptoms was relevant in selecting the homeopathic remedy and for some participants it was important to make connections between their history and the present. In this study, causation of illness if known, was so varied that it is not possible to make any generalisations about its impact on the treatment process. It may be useful, however, to consider changed perceptions about past events which occurred after homeopathic treatment. These changed perceptions may have had an impact on the outcomes of treatment.

### **4.3.3 The principles and process of homeopathic treatment**

“Like invisible mending, homeopathy is often a job well done (by a well prescribed remedy and the conduit of the perceptive practitioner, grounded in homeopathic philosophy) so that no one can see any evidence of the threads of the homeopathic healing process.” (Evans 2006: 75)

Holistic models of health care aim to treat the whole person and take account of the physical and emotional symptoms, as well as lifestyle and life experiences. This is an appropriate approach for the 55+ age group who are likely to have more than one symptom and whose life experiences may have an impact on their treatment.

In classical homeopathy, decisions made about patient treatment are based on homeopathic philosophy. Reactions to remedies prescribed to patients are also assessed on the basis of a philosophy shared by classical homeopaths and based on the work of Samuel Hahnemann (1810). There was clear evidence of this philosophy in practice in the accounts given by participants of their experiences as well as the evidence of outcomes from the study. In section *1.3 Homeopathy* the origins, theory and philosophy of homeopathy are outlined, based on the work of the founder Samuel Hahnemann. In this discussion, the work of Chappell (1994) Coulter (1980) and Vithoulkas (1979, 1980) are also referred to in interpreting Hahnemann's work in a modern context.

The aim of homeopathic treatment is much more than symptom relief. Vithoulkas (1980) defines health as mental/spiritual, emotional, and physical well being. He sees the highest level as the mental plane which registers changes in consciousness and understanding. A healthy mind has clarity, coherence and creativity and the lack of any of these is a sign of illness. The emotional plane should be free of negative feelings, such as jealousy and sadness. The physical plane is the least important and in his view maintains its own hierarchy trying to keep symptoms of ill health away from vital organs. Hahnemann believed that a healthy emotional balance was based on thinking clearly, responding sensitively and acting decisively (Hahnemann 1810). The evidence in this study was that this hierarchy of healing was relevant for almost all participants and even those participants whose focus was firmly on a physical symptom, valued improvement in emotional and spiritual well being.

Homeopathic philosophy and principles offer a clearly defined approach to achieving these aims. This approach is followed by classical homeopaths and creates a common approach to treatment that is consistent, defined and reproducible. The stages of this process include the homeopathic interview and case taking, selecting the most appropriate remedy, monitoring outcomes of treatment and supporting the patient in achieving and maintaining good health. There was evidence throughout this study that

these homeopathic principles were followed rigorously. This was observed by participants and was apparent in the outcomes of treatment.

In this study frequent references are made to the role of the homeopath as the unprejudiced observer. This approach is highlighted by Vithoulkas (1980) in very similar terms. He describes each homeopathic interview as a unique process demanding of the homeopath different approaches to each patient. He refers to the need to be conscious of our own responses to individuals during the interview and develop a level of discipline which allows for objective gathering of information but also sensitivity to what the patient is truly expressing. Along with this, there needs to be a rapport which will enable the patient to share intimate feelings and experiences. He refers to the importance of the setting, requiring a quiet, harmonious, simple, aesthetic décor, free from interruptions. He regards the most important aspect of the homeopath's behaviour to be a concern for the patient's welfare and an acceptance of whatever information is shared without making judgments. He believes that the unprejudiced mind allows freedom of expression of the patient but also allows the homeopath to see the truth of the case. He talks about the homeopath having the capacity to live the experience of the patient and 'crawl into the context' of each patient.

Vithoulkas' description is a powerful account of what this study set out to do. Participants in the study noted that the approach was non-judgemental and contributed to their ability to be open about their experiences and their feelings. This approach is fundamental to the principles of classical homeopathy. They also commented on the importance of being listened to and the value of a calm atmosphere and a caring approach.

The process of listening in an empathetic way to the story told by patients is only part of the process. Coulter (1980) states that precisely observed symptoms are the most accurate measure of disease and health. Vithoulkas (1980) requires homeopaths to record the exact language used by patients whenever possible and to refrain from putting words into the

patient's mouth. It may occasionally be necessary to give examples of types of answers to specific questions. It may also be necessary to probe deeply when an answer is unclear but seems to be important to the case. This approach was followed carefully in this study. Participants' accounts of health and life experiences were recorded almost verbatim on a laptop computer and used as the basis for selecting an appropriate remedy. Participants were gently encouraged to say more about their symptoms. This is described by P14:

“a lot of it is tell me how you feel, tell me how you felt, tell me what's changed ... that releases other memories and thoughts” (P14 L132)

The use of examples by the homeopath to facilitate dialogue with participants was referred to by Vithoulkas (1980). This approach was used with great care in this study. It was also subjected to scrutiny in the practitioner's reflective journal to evaluate the focus of any examples used, asking if it was for the benefit of the participant or if it met some need of the practitioner to tell her own story. There was little evidence that this was the case but it was a concern as some of the experiences were shared by practitioner and participants. In one instance, the reflective journal revealed that an attempt to avoid making assumptions about shared experiences had led to more probing questioning than was appropriate for the participant.

The homeopathic interview is designed to allow the patient to tell their story in their own way. This can be seen as similar to counselling and there are similarities in the non judgemental, listening approach, but in homeopathic practice there is no attempt to analyse the story or to resolve any issues discussed. Vithoulkas (1980) believes that patients with chronic illness harbor deep within them feelings or memories of experiences which cause them great distress. Bringing these deep feelings out in the open is a subtle and sensitive process.

This was certainly true in this study. Participants expressed surprise that they spoke about things that they had not spoken of for a long time, or had never told anyone else, or would not consider appropriate to share with friends. These stories were of significant

trauma. Listening to accounts of abuse, loss and trauma was harrowing at times. Individuals telling their story showed different levels of emotion, some telling the most difficult stories were calm, others speaking of losses that might not have been expected to touch them showed extreme distress. All spoke of the value of sharing their story in terms of understanding it themselves, revisiting grief and loss in a caring setting, or a feeling of unburdening themselves of something painful.

Chappell (1994) believes that homeopathy incorporates the concept of vulnerability of individuals, so that each person is affected differently by similar experiences. This vulnerability may not be apparent in our outer personality but this often hides the weaker inner personality which is more childlike and focuses on negative views of self and others. This was evident in listening to the stories of participants in this study. The anger or sadness felt by the rejection of a parent or spouse was very evident in their commentary. Their hurt and bitterness often seemed as raw as when the rejection occurred decades before. There was also evidence that after homeopathic treatment these individuals no longer focused on this hurt but talked about present issues, or stated that they had achieved some kind of reconciliation with the experience or an individual who was part of it.

Hahnemann (1810) refers to the different ways that patients present their illnesses. In Aphorism 96 he refers to patients with a temperament which leads them to exaggerate their symptoms in order to get their physician to do more. In contrast, in Aphorism 97 he refers to the patients who withhold details of their symptoms or regard them as too insignificant to mention. Vithoulkas (1979) also refers to the careful patient who is cautious about reporting changes in symptoms until absolutely certain about them for fear of misleading the homeopath. He notes that there is a wide variety of symptoms expressing themselves in every part of the patient's life and these must be taken into account too: relationships, work stresses, reactions to different experiences, food cravings, quality of sleep and changes in personality or mood. He describes homeopathy as a demanding system of medicine for the patient, requiring objective self observation,



sympathy for the task facing the homeopath, and the wisdom to be patient during any healing crisis. These perceptions are very relevant to this study, where there was evidence of very complex narratives of life experiences and health issues.

Vithoulkas' (1979) view that both patient and homeopath are involved in the process is relevant for this study. Participants' beliefs in homeopathy were varied and seemed to have less impact on the outcomes than their commitment to the process and the treatment. They spoke of honestly trying to describe symptoms and changes after taking the remedy. They referred to conscientiously taking the remedy every day and were quick to 'confess' if they missed a day and give a good reason for this. If signs of a homeopathic aggravation or return of old symptoms appeared, they were interested in what was happening and recorded the experience faithfully. It may be that explanations provided with the remedy and given at the consultations reinforced this behaviour, but they also said that their commitment increased because they saw signs of improvement or because something was happening. This commitment was also evidenced by attendance at all four consultations by all participants.

The process of homeopathic treatment is closely linked to the philosophy of classical homeopathy and was carefully adhered to in this study. This process does have connections with other therapeutic approaches, but the use of the homeopathic remedy is the distinguishing characteristic. The themes outlined by participants in the study relating to their experience of taking the homeopathic remedy have strong links with the philosophy of classical homeopathy.

#### **4.3.4 Participant experiences of taking the homeopathic remedy**

Homeopathy is based on the choice of a remedy that matches the symptoms of the patient as described by him or her and observed by the homeopath. The original Greek word homeopathy means 'similar suffering'. A good match between the symptoms and the remedy is called the *simillimum* and the outcome of taking this remedy is expected to be

improvement in both physical and emotional health. In several cases in this study, this outcome was observed and noted by the participants. Vithoulkas (1979) asserts that only one particular remedy is needed at any stage of an illness and cure will only come about if that remedy is found. He refers to the individualised nature of prescriptions, chosen to match the patient's specific symptoms not the formal diagnosis. He quotes Aphorism 7, in which Hahnemann (1810) refers to the totality of the outward symptoms which reflect the inner sickness and the appropriate remedy for both.

The action of the remedies is described in *Materia Medica* (see Appendix 3 for an extract from a *Materia Medica*) as it was experienced by participants in the proving process (see Appendix 1 for information on provings). These descriptions have come to be known as remedy pictures. In this study, participants were given brief accounts of remedy pictures as examples of the type of symptoms that homeopaths look for. The participants were often quick to dismiss a remedy picture as irrelevant to them or to confirm that a particular description seemed close to the way they felt. These discussions were never used to prescribe remedies but did give both homeopath and participants a sense of how remedies might relate to them. P14 went as far as to question whether the reading of the remedy picture had been the significant part of the process for him.

“if anything I’ve become more interested in what actually makes it work. I’m fascinated that you sit with books that are over 100 years old on the subject, you know.” (P14 L91-93)

“...I have to be convinced that the remedy did have an impact, but it might just be because you told me that that was the remedy that worked for somebody who you were able to describe as being me from the good book you keep reading from and I might have thought well that’s me so this will work” (P14 L147-150)

The remedies and associated remedy pictures selected for participants in this study were closely related to the symptoms and the stories told by the participants. Not surprisingly, remedies that feature grief were important such as *Natrum Muriaticum*. The *Natrum Muriaticum* patient is emotionally very sensitive and wishes to avoid being hurt at all costs, becoming introverted to protect themselves from a great feeling of vulnerability.

This remedy was prescribed to six participants in this study (see Appendix 11 for details of all remedies prescribed).

The remedy Silica was prescribed to two participants. It is a remedy for people who lack ‘grit’ and often agree with others rather than assert their viewpoint. One participant disliked the description of lack of grit, believing it suggested that she was not tenacious, but strongly agreed with the view that she did not always argue her case and accepted decisions that she found unacceptable. She also spoke of feeling disconnected from others. Quinn (2008) describes the remedy Silica using the term ‘disconnected from others’ and notes that after successful treatment the individual feels in touch with those around him again. He goes on to describe the state of non-acceptance of self and a separation from self. This is described by the participant in the same way:

“there was a gradual moving away from my feeling of utter disconnectedness back to a greater sense of commitment to life in general” (P9 L61)

Another commonly prescribed remedy in this study was Rhus Tox. It is well known for its ability to help joint pain. Interestingly, problems in the eyes often respond well to this remedy too. This was noted by one participant when she was explaining that the remedy was not placebo because she had not been told to expect particular reactions:

“a placebo effect, yes can make you feel better but it cannot produce specific reactions or I suppose it could if you had been told to look for them, but I hadn’t, you didn’t say to me ‘Boy you’re going to get the giggles after this. Boy you’re going to feel good. Boy will you feel as if your whooping along and your eyeballs by the by will no longer be bloodshot, they’ll all be sparkling, nice and white and clear again.’ You didn’t do any of that, you didn’t say a word to me. It would have been quite interesting if you had, I would have thought you were off your head and hopped out the room fast.” (P7 L113-119)

Homeopathic remedies are prescribed in different potencies based on the number of times they are diluted. Vithoulkas (1979) defines homeopathic remedies as ‘dynamic’ and he also refers to the ‘vibrational frequency’ of each remedy which must be similar in nature to the symptoms in order to effect a cure. This is relevant to the choice of potency of the

homeopathic remedy. In this study, all participants were prescribed remedies in the LM potency, starting with LM1 and progressing to LM2 and beyond if appropriate. The remedy is taken as a daily drop and this gives the benefit of repeating the dose and some flexibility to stop the remedy if there is a significant reaction. (Remedies prescribed in tablet form are frequently taken on one occasion only, and the patient then waits for a reaction.) There is a possibility that taking the remedy daily also reinforces the belief that it will be beneficial. The use of affirmations in complementary therapies is designed to have this effect. Simpson et al (2006) suggested that following a drug taking regime has positive effects on health even if the tablet taken is a placebo. In this study there was no strong correlation between participant beliefs and outcomes of treatment, suggesting that the daily drop did not reinforce beliefs about homeopathy.

After a remedy has been prescribed the patient and the homeopath must watch and wait to see what reaction there is. This is a very important part of the homeopathic process and it can be a time when misinterpreting signs and symptoms leads to a wrong prescription. The remedy reaction favoured by some practitioners and patients is the homeopathic aggravation. This can be experienced by patients who react to the remedy initially by an exacerbation of symptoms. This worsening of symptoms is followed by an improvement, usually in the main symptom, but also in well being and possibly other symptoms not associated with the main symptom. In this study there was evidence of homeopathic aggravation, but usually at a very low level and this was limited by stopping the remedy for a few days. One participant said it “wasn’t pleasant for two days...but certainly gave me the impression that something was happening” (P3 L48).

Sometimes the process of watching and waiting is difficult for patients who are keen to see improvement and put pressure on the homeopath to change the remedy. This did happen in this study and it was difficult to resist this pressure. One participant was anxious to try another remedy before the study ended and this led to a prescription that was perhaps not timely. It is also common for symptoms to continue to disappear after the period of treatment and even after the remedy is no longer being taken. Sometimes

these are subtle changes that are less obvious to the individual than they would be to a homeopath. In this study, several participants continued to send reports of improvements after the study was completed. One participant who complained of 'heaviness' and wanted this symptom to change, did not report any improvement during the study but some months later had achieved a much lighter weight and feeling of lightness.

Homeopathic philosophy also requires observation of any symptoms that develop after the remedy has been taken. This is described as the direction of cure. Kent (1900) refers to evidence of disease on the surface of the body as a sign that patients are recovering. Participants in this study reported skin rashes and sneezing, followed by improvement in specific conditions and their general well being.

Coulter (1980) describes this as Hering's law and refers to the movement of symptoms from the surface of the body to the interior, and from the lower part of the body to the upper, and from less vital organs to more vital organs, as the disease becomes more chronic. The evidence of improvement in health is the opposite movement of symptoms and skin eruptions are seen as a positive manifestation of the body's ability to cure by moving symptoms to the outermost part of the body away from vital organs. Coulter also notes that many forms of suppression will be brought out by the remedy. This seems to have happened for several participants in this study who developed skin eruptions after taking the remedy.

Homeopathic philosophy also places emphasis on improving health generally and removing the maintaining causes of ill health. Vithoulkas (1979) asserts that the only way to cure illness is to increase the health of the person who is ill. He believes that it is the most effective natural medicine available for chronic illness. Hahnemann (1810) describes the physician as a preserver of health, identifying and removing causes of ill health. In this study, self care was included as part of the definition of homeopathy as a complex intervention. Basic self care advice was provided in writing but the focus was on encouraging participants to identify the self care methods that they felt would suit them

best. There was also the possibility that taking part in a health care study might motivate the participant to engage in self care methods that had been discontinued. In general, participants reported that taking part in the study had no effect on their behaviour in terms of self care. Some participants resumed activities that they took part in before because they felt better in themselves. Others believed that they already took care of themselves and no specific changes were required. Their case notes confirmed this view.

The evidence from this study is that the philosophy and practice of classical homeopathy was followed carefully and that participants were aware of this. The approach taken was consistent with that used by other classical homeopaths and followed a defined process. The evidence of this process was consistent with that recorded by modern homeopaths such as Chappell, Coulter and Vithoulikas, as well as that of the founder of homeopathy, Samuel Hahnemann. The participants in the study made the connections between the experience of taking the homeopathic remedy and the evidence of the philosophy of homeopathy in practice.

#### **4.3.5 Participant beliefs about the therapeutic relationship**

“The art is to enlist the patient as an ally in the struggle to make the best of the circumstances.” (Thompson 2005: 188)

The value of the therapeutic relationship in promoting health and well being is explored in section 1.2.3. *The therapeutic relationship and the patient's story*. Spiegel and Harrington (2008) specifically comment on the added value of quality time spent with a clinician. The therapeutic relationship may also be an important factor in homeopathic treatment. The nature of a complex intervention is that any of the factors included in the intervention may be responsible for the outcomes of treatment. In this study, there were varying views about the impact of the therapeutic relationship on health and well being, but there was a common view that the relationship with the homeopath and talking about life experiences and health issues was valuable.

The relationship between patient and homeopath begins in the consultation. Although this involves conversation between the homeopath and the patient, this suggests more of a dialogue than actually takes place in the homeopathic consultation. It is a conversation because two people are talking to one another and the empathy and sharing involved makes a strong connection between them, but the role of the homeopath is limited by the homeopathic philosophy that defines the role of homeopath as that of an unprejudiced observer. Vithoulkas'(1980) interpretation of this as a caring and supportive role informed the approach used in this study. It was, however, important not to lead the participant. The role of the homeopath was to instigate meaningful contributions from participants in terms of information that would help to select the remedy.

Most participants spoke of the value of talking about their life and health experiences. Some had never spoken of specific experiences, but most had shared their story before with health professionals, family or friends. The homeopathic consultation has a particular focus and approach which suggests that it offered something which participants had not experienced in other settings. The nature of the homeopathic conversation seemed to allow them to review and reflect on experiences and make connections that had not always been clear to them before. Even the process of saying out loud what they felt may have had an impact. Participants valued the process of being listened to without comment or judgement. This relates to the view expressed by Siddell (1995) that accounts of life experiences and illness are different in different settings. Public accounts are more linear, whereas private accounts given in a therapeutic setting often link current health experiences with past life events.

Participants also commented that the homeopathic conversation was enlightening, suggesting that new perceptions had been gained. The evidence of this was often seen in later consultations when participants presented a different view of a relationship or past experience. It is difficult to evaluate the importance of this aspect of the homeopathic process in terms of health outcomes but it was a common theme in participant discussions of their experience.

Participants also commented positively on other aspects of the treatment process including the venue, contact with the homeopath between appointments and being part of a research study. It is difficult to measure the contribution of these factors to outcomes of treatment but it seems likely that they contributed to the open and trusting relationship with the homeopath which is essential to successful remedy choice.

Another theme that was common in the research evidence was the value placed on the sense of being cared for. One participant highlighted this in her interview.

“It’s because it’s unusual in this day and age to get the sense that perhaps someone really cares about you one way or the other and I would have thought that since the research project is about well being for older people, even older than I, if someone is elderly and perhaps a little bit vulnerable then that kind of supportive and caring, you know the fact that you’re being followed up and someone is interested and what not, but then I think that’s splendid, partly because it’s unusual.” (P13 L103-108)

It seems important to note that this approach was intended by the practitioner and valued by the participants but cannot easily be measured or reliably reproduced as a factor in health care.

Additionally participants seemed to ‘enjoy’ the homeopathic treatment process. Many participants spoke in different terms of gaining pleasure from the homeopathic process and the interaction with the homeopath. This was expressed clearly in the following interview response.

“it’s quite a, not an intimate relationship, but it’s quite a close relationship and therefore if you didn’t feel a sort of rapport and a good feeling well then you would clam up” (P13 L91-93)

Participants valued the opportunity to talk to someone about their experiences in a calm and non-judgemental context.



Mitchell and Cormack describe the benefit of telling one's story to someone who is genuinely interested:

“who listens, who appreciates its relevance to the person's difficulties can be a profoundly therapeutic experience in itself. Many patients feel that at last they and their suffering have been taken seriously.” (Mitchell and Cormack 2005: 101)

This was true for some participants in this study who found it helpful to be heard and gained hope from the process of treatment.

“I think coming here for these appointments gave us a bit of hope” (P6 L29)

Stone and Katz (2005) highlight the rapport between client and therapist as part of the healing process. Siddell (1995) refers to the value of having time to explore the patient's account of illness in a non linear way. Spiegel and Harrington (2008) conclude that many people who visit a CAM therapist may experience significant benefit from the opportunity to talk about their experience of illness to an empathetic listener. They believe that the therapeutic relationship should be valued as a specific healing tool. The ‘package of care’ effect is specifically referred to in the Cochrane reviews of homeopathy (The Cochrane Collaboration 2010) stressing the importance of the homeopathic consultation as well as the remedy.

#### **4.3.6 Participant beliefs about homeopathy, health and healing**

Chappell (1994: 96) states, “Remedies are stronger than your inhibitions, suspicions and scepticism.” In his view, even non-believers in homeopathy will get better if given the correct remedy for their symptoms. If the chosen remedy resonates with the inner mind-body disease process, it will remind the body of the healing stimulus that seems to have been forgotten. This view contrasts with the research evidence that beliefs do have an impact on healing as described in section 1.2.2 *Beliefs about health, illness and ageing* and section 1.2.4 *The placebo effect*.

In this study there was no clear evidence that beliefs about homeopathy had an impact on outcomes. Participants were surprised by unexpected outcomes and disappointed when expected outcomes did not occur. Knowledge about homeopathy before treatment was limited and there was no evidence after treatment that participants could give an account of the philosophy associated with homeopathy. Participants spoke of having an open mind or being willing to try homeopathy because nothing else had worked for them. When asked which aspect of treatment made the most difference to her health, P13 said, “overall I’m feeling better so I don’t care which has helped me” (P13 L132-133). This was a view echoed by other participants in the study. P7 also referred to not understanding how homeopathy worked, and not understanding how conventional medicine works either, but questioned whether it mattered so long as it worked.

Participants in this study did have more definite views about the placebo effect, but not a common view. Some participants felt very strongly that improvement in their health could not be related to placebo as they had no prior knowledge of what might happen and were frequently surprised by their response to a remedy. This links with research carried out by Mollinger et al (2009) which provided evidence that the effect of the remedies is different from any effect produced by a placebo but relates closely to the experience of homeopathic provings. Sherman and Hickner (2008) also argue that the placebo effect is related to expectations. In this study very few participants had specific expectations about the outcome of homeopathic treatment.

Other participants in the study believed that the placebo effect is part of all treatments and therefore cannot be discounted in homeopathic treatment. These comments were not connected with beliefs in homeopathy but with beliefs about any health intervention. This view seems to be supported by the literature, which offers examples of improvement using placebo surgery, placebo medication and placebo CAM, such as acupuncture. This effect is so well known that it is factored into results for research studies when the significance of outcomes is calculated and the results are described as significant only if

they score higher than would be achieved with placebo alone. Di Blasi (2005) refers to the typical placebo effect on about a third of any study population

Thompson et al (2006) refer to the difference between placebo as medicine and the placebo effect. They believe that individualised homeopathy is a complex intervention with many potential non-specific effects. They attempted to discover the active ingredients in the homeopathic process during a research study at the Bristol Homeopathic Hospital. They found unique aspects of the homeopathic process were active ingredients, such as the remedy matching the individual's symptoms and story (Thompson et al 2006).

As well as beliefs about homeopathy and placebo, some participants had beliefs about their faith and its potential to heal. Three participants spoke specifically about the importance of prayer and their faith. The faiths were different, but all followed the religious beliefs of the country they were born in. One participant attributed his recovery to his faith, although this had not had a healing effect before treatment. Sternberg (2000) suggests that belief systems can improve health. These include conditioning, ritual, prayer and meditation.

Measuring beliefs is not easy and it would require further research and different methodology to examine the beliefs of participants in this study about homeopathy and other healing interventions. The evidence gained from interview questions and the initial consultation suggests that only a limited number of participants had positive beliefs about homeopathy, based on past experience of using it, but most had no view about whether it would offer positive health outcomes. Most participants had a very limited understanding of the meaning of homeopathy. The evidence in this study suggests that outcomes were unrelated to knowledge of the remedy picture or beliefs about homeopathy or other healing interventions.

### **4.3.7 Interpretation of thematic evidence**

Paterson et al (2009) explore the use of outcome measures in research on complex interventions and suggest that outcomes are viewed as freezing experiences at one time point, ignoring the process and context of healing. They cite the example of drugs that are known to have maximum effect at a certain time point, for example, an arthritis drug that is most effective eight weeks into treatment, and that is when its effect is measured. Paterson et al (2009) stress the need to include interaction between components and context. This approach was an important part of the design of this study. By using both quantitative and qualitative data, it was hoped that greater insight into the process of achieving outcomes would be gained.

Charmaz (2006) sees interpretative qualitative research methods as a means of entering the research participants' world. The extent of the interpretation of research data is defined by the chosen methods for analysing data. In this study, the aim was to present data that provided a clear statement of the participants' experience of treatment rather than the researcher's interpretation of that experience. The purpose of this approach was to avoid distortion of data and increase the trustworthiness of the research.

Selection and analysis of thematic data involves some interpretation of participants' meaning as the views of individual participants are grouped together under thematic headings. Further interpretation involves Charmaz's concept of entering the participants' world and trying to make connections with their experience. This also encompasses the view of Paterson et al (2009) that it is important to go beyond outcomes and consider connections between components and context.

The thematic analysis of data in this study seems to confirm the strong connection between the experiences of participants in the study and homeopathic theory and philosophy. In contrast, the connections that might have been expected between beliefs about homeopathy and healing do not seem to be confirmed by thematic analysis of

participants' interview responses. Although life experiences in the study cohort were often very different, the common experience of facing challenges and coping with different emotions was evident in the thematic analysis. The impact on health of coping with trauma and diversity was also evident. The value placed on the opportunity to revisit these experiences and share the story with a non-judgemental listener was also clear. Thematic analysis of interview data confirmed that homeopathy as a complex intervention had much to offer participants in the study.

The thematic evidence in this study also relates to context effects. Verhoef et al (2002) identify context effects as those aspects of treatment that enhance interventions, including the effects of the physical and psychosocial context in which an intervention takes place. Participants in this study made clear reference to the value placed on a calm, professional context for health care. They valued the interaction with a caring professional and the shared journey in the homeopathic experience.

The common themes found in participant interviews in this study reflect their views of the homeopathic treatment process, focusing on the experience of many participants of successful outcomes of treatment in terms of improved health and well being. There are strong connections between their experience of treatment and homeopathic theory and philosophy. They also value additional benefits that are part of the homeopathic treatment context and process.

## **4.4 CHOSEN RESEARCH METHODOLOGY FOR THIS STUDY**

The pragmatic approach taken in this study takes account of both biased and unbiased perspectives and combines different methods of data collection in order to view participant experiences in different ways. All possibilities are valued and examined without expectation of finding definite answers to the research questions.

### **4.4.1 The research questions**

The research study aimed to answer the following two questions:

- ❑ Is homeopathy perceived to be effective in improving health and well being and quality of life in the 55+ age group?
- ❑ What are the common themes in the experience of homeopathic treatment described by participants in this study?

Willig (2001) states that the research question defines and limits what can be revealed by a research study. The first research question limits this study to the 55+ age group. This is a large part of the population which is under represented in research studies (Greenhalgh et al 2000). Most major studies of homeopathy have included all age groups. There is no upper age limit but only the 55–70 year old age group took part in the study. Those who took part represented ‘the walking wounded’ or those who did not have illnesses which prevented them from travelling to a clinic for treatment. They also had to climb stairs to the treatment room, and one participant pointed out that this was not suitable for anyone with a disability. Older people in the population, over the age of 70, are not represented in this study and therefore results are not necessarily relevant to all the 55+ age group.

A further limitation was that the research question referred to perceived health and well being. There were no objective measures used to test health outcomes, only the views of the participants in the study. The difficulty in measuring health, well being and quality of

life is that these are all subjective topics, experienced differently by individuals and in different contexts. The second research question also focuses on the views of individuals, attempting to capture the nature of the homeopathic experience by recording the views of participants in the study and exploring common themes. This is an appropriate question when taking a pragmatic approach to research but may make it more difficult to draw conclusions from the research evidence.

#### **4.4.2 Mixed methodology**

According to Cohen et al (2000) many researchers value the use of mixed methodology but in practice few researchers use more than two methods of data collection. They assert that using one research method may bias the researcher's view or distort the outcome. The use of several methods of data collection enriches the research findings and encompasses more fully the complexity of human behaviour. In terms of reliability and validity of research methods, triangulation or similar designs increase confidence in the outcomes of research studies.

The use of an embedded design for this study took account of the need for reliability and validity by using qualitative data as the main source of evidence and quantitative data as supportive evidence of outcomes. There is no convergence of data as in triangulation but each data set is presented separately. In this study the secondary results from quantitative data positively supported results from the qualitative data, the primary source. This connection strengthened and developed the research evidence.

The use of both qualitative and quantitative methods in this research study have provided varied sources of evidence on the use of homeopathy for the 55+ age group. This view is supported by Enderby (2007), who believes that mixed methodology provides a different angle on the same truth. There has been coherence in the evidence from the different research methods which has increased the strength of the research findings. It allows for the presentation of individual cases, providing a richness of data and individual insights

into the experience of homeopathic treatment, but also allows for presentation of results for the study cohort. In contrast, the thematic analysis of the views of individual participants compared with results from quantitative data did not provide additional explanation for outcomes of the study. Instead it revealed once again the diversity of viewpoints in the study population about the impact of different aspects of treatment on their health and well being. Overall the use of a mixed methodology has supported the pragmatic approach to research which underpins this study. It revealed the richness of participant contributions, allowing them a strong voice in the data presented, reflecting a range of different perspectives on health, homeopathy and wellness in the 55+ age group.

#### **4.4.3 Qualitative data**

Reid et al (2005) believe that the interviewees are the experts on their experience. Creswell et al (2008) also value qualitative data as a way of hearing the voice of participants in any study. They do, however, acknowledge the difficulty in generalising results from qualitative data. They caution that the data may be less objective than quantitative data.

The qualitative evidence in this study includes the interviews with participants, the case notes and the use of a reflective journal by the homeopath/researcher. Only the interviews with participants were specifically designed to gather information about the outcomes and process of homeopathic treatment. Both the case notes and reflective journal provide a subjective account of the experience which was not specifically designed for research purposes but was part of the homeopathic treatment process. The importance of including evidence from both these sources is that they provide a valuable individual perspective on the experience of homeopathic treatment and a very detailed review of outcomes at different stages of the process. This enriches data gathered from other sources and offers opportunities to confirm and compare participant accounts of the experience of homeopathic treatment.



In this study, the most useful data was gathered from participant interviews. Questions were directly linked to participants' experience of homeopathic treatment and expressed as clearly as possible with no attempt to elicit a particular type of response. Direct quotations were used to present participants' views so that they were not summarised or interpreted by the researcher. Themes were selected by considering the most frequent references and the most important issues for the participants. Inevitably, the selection process meant that some data was omitted and therefore the themes chosen may be exclusive of issues that were significant for individuals.

The thematic analysis provided useful insights into the experience of homeopathic treatment for both individuals and the study cohort. Some themes provided strong evidence of a common view for all participants, for example almost all believed that the homeopathic remedy had an impact on their health and well being. The thematic analysis also contributed to a greater understanding of what participants valued in the treatment process, such as the calm venue and the non-judgemental approach of the homeopath. This greater understanding provides valuable information for both homeopaths and health care providers about what is important to the participants in this study, and potentially others in the 55+ age group.

Thematic analysis also revealed the diversity of viewpoints in the study cohort, particularly about the impact of beliefs on health and well being. Most participants valued the opportunity to tell their story and some spoke of a greater understanding of their past and its impact on their health, but there was no consensus about the impact of telling their story on improvements in their health and well being. Overall, it seems that the use of a thematic approach to analysis of interview data provided some evidence of common views across the study cohort but also highlighted differences of opinion. As a research tool, thematic analysis provided an important opportunity to explore the qualitative data, particularly the interview scripts and to gain a greater understanding of what was important to the participants in the homeopathic treatment process.

One limitation of this approach is that the research and the treatment are not separate processes. This means that information gathered in consultations is not designed for research purposes but is used as evidence. This is limited by issues of confidentiality and participants expectations that they are free to speak about personal matters that will not be identified in the research.

The roles of homeopath and researcher are not incompatible, but it may be more difficult to limit bias and subjectivity if the same person carries out both roles. The benefit of this combined role is that there is an understanding of the homeopathic philosophy in the interpretation of outcomes. It is also believed that participants are more open with a researcher/practitioner who they know and trust (Giorgi and Giorgi 2008). Using an independent researcher to investigate the effect of homeopathic treatment could have reduced the risk of bias and allowed participants to be more openly critical of the process. In this study, participants were very clear that they had attempted to answer questions honestly and were not influenced by the homeopath/researcher.

#### **4.4.4 Quantitative data**

The MYMOP and SF-36 questionnaires were chosen as the most frequently used methods of gathering data on the use of complementary therapies, and on well being and quality of life. The results from both questionnaires support the information gathered from interviews, case notes and the practitioner reflections. Dawson et al (2010) refer to the widespread use of patient reported outcome measures (PROMs) to provide evidence of patient perceptions of treatment outcomes. These measures are described by them as a useful means of assessing outcomes of healthcare interventions, but they are unlikely to reveal the reasons underlying any change in health status. PROMs can focus on a specific disease, for example, Parkinson's disease, hip and knee replacement, or relate to general well being. They are used increasingly in the NHS as a response to government led

initiatives to inform choices about individual care and manage performance of health care providers.

MYMOP is designed to be a simple questionnaire for participants to complete. Paterson (1996) believed the use of a numbered scale made the questionnaire more sensitive in terms of recording change than questionnaires that ask if symptoms are better. MYMOP often shows a gradient of improvement over time.

In this study most participants did find the MYMOP forms short and easy to complete but still some errors occurred. This was particularly noticeable when participants changed their chosen symptoms at the next consultation so that the same health issue was not being scored. This may be resolved by offering more advice before completion of the forms, but it is also likely that in a bigger study these errors would have been less noticeable.

MYMOP is also based on symptoms and therefore seems less useful for measuring a holistic treatment. Jenkins (1996) is critical of this symptom based approach to research, as presenting symptoms are not always the main reason that individuals seek treatment. Haidvogel et al (2007) confirm that outcome measurements do not address all the potential benefits of CAM interventions, particularly the effect of the therapeutic relationship and the focus on individual and holistic health issues during treatment. Sternberg (2009) also regards it as a weakness of MYMOP that it is symptom based, which does not correlate with homeopathic philosophy. This was evident in this study as some individuals selected symptoms for the purposes of the MYMOP questionnaire which they stated in the case notes were not their key concerns.

SF-36 appeared to be more complex for participants to complete and there were errors in the completion of some questionnaires, particularly when scoring was reversed on the form. For participants who were particularly unwell it was difficult for them to concentrate on the complexities of the form. Conversely the more complex nature of the

form did in some ways seem to increase concentration and participants genuinely appeared to try to complete it accurately. Lyons et al (1994) and Hayes et al (1995) carried out research to assess whether it was a suitable measure of health outcomes in older people but found evidence of its sensitivity and validity, particularly when used in an interview setting as it was in this study.

Giving a score to a symptom or a belief is inevitably subjective and there was evidence in this study that responses were affected by life experiences. The score for the well being question reflected experiences of recent bereavement or concern about sick relatives. Several participants experienced minor conditions like colds or dental treatment which affected their scores on the well being question. (One participant wrote on the questionnaire that he had a bad cold.) The responses to the questionnaire reflected how participants felt at the time of completing it and this may not have been entirely representative of how they felt in general or as a result of the treatment received.

SF-36 is useful for comparing health issues with general population norms, but it may be useful to consider a version of SF-36 that is more suitable for older people, for example, asking about tasks like bed making rather than strenuous exercise and including questions about sleep.

The responses to both questionnaires in this study were inevitably subjective. Individuals interpreted the meaning of the choices for each question, for example, stating that health was very good or poor was a subjective choice. These choices seemed to be based on how they felt on the day of completing the questionnaire, rather than reflecting an overview of their general health. SF-36 asked participants to focus on the previous month which suited this study because most appointments were at monthly intervals but the evidence was that the views expressed related to the way participants felt on the day. Not only is health a very subjective issue but it is also experienced in the moment.

The limitation of using questionnaires to evaluate health and well being is that they may not be sensitive enough to capture changes that take place over time for individual participants. Scoring specific symptoms in MYMOP also did not reflect changes in other aspects of participants' health. Dawson et al (2010) refer to the limitations of PROM's and these seem to be particularly important when measuring outcomes in CAM research where the evidence of change may be more holistic or unrelated to the questions asked.

#### **4.4.5 The role of homeopath and researcher**

In this study the researcher was also the practitioner. The most important benefit of this approach is the knowledge of the homeopath which allows for greater understanding of participant experiences and the ability to link these with homeopathic theory and philosophy. It also provides an opportunity for the researcher to build a trusting relationship with participants (Martens 2008). There is a risk of bias but by acknowledging this risk and subjecting the research process and evidence to the scrutiny of supervisors and other professionals it is hoped that this bias was limited.

An additional concern is whether the approach taken by the homeopath is consistent with that taken by other homeopaths and if the personality of the homeopath/researcher had an impact on the participants in the study. The approach taken in the homeopathic consultations was very closely linked to the approach described by the founder of homeopathy, Hahnemann (1810) and more recently by Vithoulkas (1979), adopting the role of unprejudiced observer, offering interaction only to support the participants' ability to tell their story. The approach used at each consultation was consistent and evidence was recorded, stored and eventually analysed in a consistent way. Participants clearly stated that they were not influenced by any desire to please the homeopath and attempted to truthfully give an account of changes that took place in their health and well being.

It is unusual in a research study to get 100% attendance at all appointments and for all participants to complete the study. This suggests that something in the person of the

homeopath/researcher or the process of treatment motivated participants to attend all appointments and comply with agreed treatment regimes. In response to interview questions, participants were clear that they had been compliant in taking the remedy and most also recorded changes in their health and well being, either in writing or as part of a reflective process that supported the consultations.

It is not possible to evaluate the impact of the individual homeopath/researcher on the outcome of treatment. The use of an independent researcher and more probing questions about the impact of the relationship with the homeopath might be a useful addition to similar research projects in the future.

#### **4.4.6 Reflexivity**

A practitioner's reflective journal and the process of questioning research methodology were used to promote reflexivity in this study.

The reflective journal was used conscientiously to record thoughts and feelings about the consultations with participants and any contact with them between appointments. It was to some degree an extension of the case notes, focusing almost entirely on the treatment process and the role of the homeopath in facilitating the treatment process. The structure of the document was based on the dates of appointments. It was not amended or edited after the practical part of the study was completed. This suggests that it was an honest account, based on views held at the time of seeing participants. It was most valuable in assessing the process and outcomes of treatment. This was based on professional judgements about what was heard and observed in consultations.

As a document to provide an outlet for emotional issues and for personal experiences that might have had an impact on treatment, the reflective journal for this study was surprisingly barren. As many reflections had taken place on the personal issues that might have had an impact on the study it was surprising to find that they were not recorded in

the journal. Comparisons with journal records in the early days of practice show that a change had taken place in the type of entries in the reflective journal. The most likely explanation for this seems to be that experience changes the need to reflect on certain aspects of practice. As a contemporary of participants in the study, and as a parent, a grandparent and daughter of older parents, there were many personal connections that could be made with the stories and experiences of the participants. There was surprisingly little comment on these common experiences in the reflective journal, suggesting that there was a separation in thinking between the role of homeopath and the experiences shared with participants. The reflective journal did focus on research issues and made comparisons between the role of researcher and homeopath, focusing attention on feelings about the processes involved in both roles.

The individual stories of participants included tragedies and perspectives which were not common experiences between homeopath and patient. Listening to these stories was often moving, sometimes shocking and required a degree of detachment as well as empathy. Kuipers (2008) outlines the risks of unconscious empathy when listening to a patient's story and recommends empathic concern. She believes that by consciously empathising with patients, homeopaths reduce their susceptibility to compassion fatigue and burnout. She defines empathy as being able to show understanding of the patient's perspective by communicating a response. Empathy with patients is likely to enable them to feel safe to tell their stories or express emotion. This reflects the views expressed by participants in this study, but the reflective journal assumes this approach rather than analysing the need to maintain this empathic concern.

This professional detachment and use of empathic concern, may have limited the use of the reflective journal for personal reflections. The focus is frequently on practical tasks rather than emotions and on the use of standard procedures as part of a professional approach to practice. There is evidence of professional confidence, based on reflection on past experience, that procedures used in practice were helpful and well linked to homeopathic philosophy on case taking and the role of the unprejudiced observer.

These journal entries on professional practice include references to standard procedures such as asking participants to complete forms giving information about health history, ensuring that factual information is not lost during the narrative part of the consultation. The use of medication in the 55+ age group was also a concern and reference was made in the journal to the need to constantly check details of pharmaceutical medicines and their side effects. The style of the consultation was also mentioned, valuing the thorough nature of the process, the calm atmosphere and good time management so that consultations were well paced. Reference was also made to the early years of practice and the benefits gained from reflective practice at that time, which made current choices about setting, appearance and behaviour part of a routine which ensured consistent professional practice. These references all highlighted the need to maintain high standards and a professional approach to practice.

This professional approach also includes respect for all individuals who seek homeopathic treatment. The reflective journal revealed a non-judgemental approach to participants in the study. There were no comments made about them as individuals or judgements made about appearance or behaviour. This unconditional positive regard seems to have been genuine and sustained except for one aspect of the study. Charmaz (2006) refers to hierarchies of credibility in which different weight is given to people or organisations with different status, suggesting that a person at the top of an organisation is more believable than those at the bottom. It is possible that participants who were professionals, or held a high level position in an organisation, or were the most articulate were the ones whose opinion was given most consideration. There is no evidence of this in any of the data, but reading Charmaz' comment raised the issue and caused discomfort.

The reflective journal included fewer references to the research process. Although there was a lack of recorded evidence, there was constant questioning of all aspects of the study and every part of the process was subjected to scrutiny by university professionals, supervisors, colleagues and even participants in the study. This was rarely a straightforward process, with different opinions expressed and sometimes a lack of



understanding of homeopathy which hampered the reflective dialogue. The discussions with professionals were recorded in follow up e-mails but these usually referred to the actions that would be taken as a result of the discussion. The most useful part of the reflective process was often discussion with supervisors when their questions and interest opened up explanations that made the research process clearer. These valuable reflective dialogues have informed amendments to the thesis itself and therefore it provides some evidence, albeit not labelled as such, of the reflective process. It would have been a more complete process if these reflections had been recorded separately.

Most of the reflective journal was about the practice of homeopathy. The themes in the reflective journal that related to the role of researcher were about feelings about being a researcher and the participants' experience of being involved in a research project. There were references to practical issues such as the scheduling of appointments which had an impact on the results of questionnaires. If the appointment was at the time of a remedy reaching the end of its action and the next level was required, less positive results could be recorded. Equally if a remedy had just been changed then it can be too soon to assess progress. The difficulty in synchronising research activities and homeopathic practice was a frequent concern.

Some participants had difficulty completing the questionnaires because they were too unwell or weary, or because the questions seemed irrelevant to them as individuals. This was referred to in the reflective journal as a concern, both in terms of the research and also any distress caused to participants.

Comparisons were made in the journal between practising homeopathy for research purposes and practice under normal circumstances. A key difference was that participants returned for follow up appointments according to the research schedule. In some cases, participants might not have continued to pay for appointments when they felt better. This would be a loss in terms of looking at less obvious health issues and also in discussing

and affirming self care practices. From the practitioner's perspective it was pleasing to be able to see participants again without payment being an issue.

Reflexivity is about questioning all aspects of research and this was done constantly and conscientiously. Participants in this study referred to the experience of homeopathic treatment as a journey. The research process was also a journey with many changes of direction and new perspectives on familiar territory. The process of reflecting on this journey was what made it so valuable and interesting.

#### **4.4.7 Evaluation of the research methodology**

##### **4.4.7.1 Innovative approaches to CAM research**

The requirement for evidence based health care has led to attempts by CAM practitioners and researchers to test out CAM therapies using the same research methods as those used for pharmacological trials. This process has led to much debate, particularly in relation to homeopathy trials. Some eminent researchers have changed their view of the approach required in CAM research as a result of this (Reilly 2006, Weatherley-Jones et al 2005). Recent literature on the approaches best suited to CAM research, informed the choice of research design for this study. The use of mixed methodology is recommended for the investigation of CAM therapies, in order to capture the experience of CAM treatment as well as the outcomes. More recent studies of homeopathy, such as Teut et al (2010) have adopted this approach. The study of complex interventions has also been developed in recent years (MRC 2008) and homeopathy has been studied to identify the components which make it a complex intervention (Thompson and Weiss 2006).

These innovations to the approaches to researching CAM have informed the choices made for the design of this study. Homeopathy has been defined as a complex

intervention and a mixed methodology used to investigate its effectiveness. A further innovation was the use of an embedded design rather than triangulation of results. The results for qualitative and quantitative data were presented separately rather than amalgamated.

These approaches seem to have been successful in producing evidence that clearly supports the perceived effectiveness of homeopathy in improving health and well being in the 55+ age group, for this study cohort. The research methods produced a richness of data that endorsed this view. The voice of the participants was clearly heard in the presentation of the data, offering a range of perspectives on the experience of homeopathic treatment which identifies what participants valued in the process and how they experienced the outcomes. The richness of this evidence and the insights of participants might have been lost in other methods of data collection and analysis. Cohen et al (2000) also suggest that providing detailed descriptions of findings and in depth analysis allows future researchers to assess the applicability and transferability of particular research to future studies.

Additionally, the coherence of evidence from qualitative and quantitative data strengthens the evidence and provides explanations for outcomes that were available because of the mixed methodology chosen. The quantitative data supported the views of participants given in the qualitative methods of data collection. The responses to questionnaires considered both symptoms of ill health and well being issues and the data collected complemented responses given in interviews and case notes. The questionnaires were chosen because of their proven validity and use in other CAM research. Their limitations are discussed in section 4.4.4 *Quantitative data*, but they clearly showed that the use of quantitative data has value in supporting data collected by other means.

The research questions in this study have been clearly answered using the chosen methodology and research design. There is evidence that this approach could be used in further studies of homeopathy, complex interventions and the 55+ age

#### **4.4.7.2 Limitations of the research methods used in this study**

The most obvious limitation of this study was that it was small and not representative of all of the 55+ age group. Although participants covered a reasonable age range from 55 to 70 years, this excludes anyone who is older. Participants came from different parts of Scotland, including both urban and rural locations but were not representative of the population generally. Most of the participants came from a professional background. Women were over represented in the study and although this is representative of the typical CAM user, the gender balance in this study was not representative of the general 55+ population.

There is also an element of self selection in any study of CAM, as those individuals who decide to participate are generally predisposed towards CAM. Mitchell and Cormack (2005) define CAM users as people who have decided to do things differently and having taken things into their own hands are more likely to take personal responsibility for their own health.

It would have been interesting to have analysed the differences between participants who took the homeopathic remedy and those who experienced all other aspects of homeopathic treatment but did not take the remedy. The one participant in this study who did not take the remedy presented in a very different way from the other participants, even though the research methods showed that the improvement in her health was similar to some other participants. Her use of conventional medication for symptom relief and self help measures was different from other participants in the study.

The results of this study are relevant to the wider 55+ population but there are limits to this relevance because of the size of the study. Although the evidence suggests that homeopathy was a valuable health intervention for the participants, the range of illnesses covered and the unrepresentative study population suggest that further research would have to be carried out before similar results could be applied to the wider population. The

use of mixed methodology provided positive evidence from different sources of the outcomes of this study and may be a useful approach for future research. It provides a way of strengthening results and increasing the possibility of relating the evidence to a wider population.

Martens (2008) makes the case for interaction between the researcher and study participants, arguing against the 'view from nowhere' in more objective approaches to research. It may be regarded as a limitation of this study that it was carried out by a single practitioner/researcher, but this may also have been a reason for the greater trust and openness described by participants. An additional benefit of using a single practitioner is that the approach is more likely to be consistent, but the dual role of homeopath and researcher requires careful management to separate the two roles and avoid bias. Even when this is achieved, it is difficult to present convincing evidence of impartiality.

A specific limitation of this study is the lack of evidence of reflexivity in relation to the research process. Although constant questioning took place and the reflexive process was thorough, the documented evidence of this is limited. There was a strong awareness of the risk of bias in interpreting data and rigorous procedures were put in place for recording, storing and checking data so that the evaluation of results was as objective as possible. This process was made more difficult because the results were generally very positive. There is a risk that this could be viewed as an interpretation on the part of the practitioner and not genuine evidence of the outcomes of the study.

This difficulty was exacerbated because the participants also gave their responses to interview questions to the practitioner. As they were commenting on the work of the practitioner, this may have made them cautious in giving their responses to her directly. The therapeutic process also meant that there was an emotional closeness to participants which could have had an effect on their responses. Participants were asked about this in the interview and they consistently stated that they had tried to be honest and had not

been influenced by the practitioner but it would have been useful to have had an independent assessment of this.

It may also be a limitation of any study into the efficacy of homeopathy that there is no clear explanation for its mode of action. Jansen (2006) refers specifically to this difficulty, suggesting that positive research results are only acknowledged if they can be explained by physical or chemical means. As homeopathy lacks a physical or chemical explanation for its action it is frequently referred to as a placebo effect and this is almost always regarded as a negative judgement. Bradford-Hill's nine criteria (1965) for causality refer to the need for biological coherence according to known facts of natural history. He did, however, de-emphasise plausibility by suggesting that biological plausibility depends on the knowledge of the time and an observed association may be new to science or medicine. It is hoped that although the plausibility of homeopathy is currently in doubt, scientific investigations in the future will eventually reveal new understanding of the action of homeopathic remedies.

Smallwood (2005) refers to the effectiveness gap when describing the lack of helpful interventions in current health care to meet the needs of individuals with chronic health problems. This is matched by gaps in the literature relating to the chronic health problems of the 55+ age group. There is also a lack of evidence on the effects of cessation of drugs, making it more difficult to evaluate the difference that might be achievable if individuals used less medication or replaced pharmaceutical medicines with other therapies. Witt et al (2008) refer to the lack of research into patient satisfaction with homeopathic health care in everyday practice. This lack of evidence makes it more difficult to make comparisons with other studies and to evaluate outcomes of this study against the findings of other research projects.



## CHAPTER 5: CONCLUSIONS

The evidence in this study shows that most participants experienced an improvement in health and well being. However the value of the study goes beyond the evidence of health outcomes. It reveals something about the way in which homeopathy met the complex health needs of the mature participants. They valued the improvements in health and well being but also the opportunity to gain insight into life and health experiences and the process of being cared for and listened to.

There were many challenges in this research study. Evaluating the effect of a holistic therapy which aims to treat the individual is a complex process, particularly as a range of factors may account for the outcomes. Homeopathy is also a challenging therapy to research as its mechanism of action is not well understood and its history is one of constant debate about whether or not homeopathic remedies can promote healing.

In many ways this is a unique study of homeopathy. Few studies consider homeopathy as a complex intervention, or for use with the 55+ age group, or draw conclusions from a range of qualitative and quantitative research measures. It is also a study that focuses on the responses of individual participants, which is very important when considering an individualised treatment method. The voice of the participants in this study was strong in identifying the outcomes and the nature of the experience.



## 5.1 OUTCOMES OF HOMEOPATHIC TREATMENT

The evidence from this study suggests that the first aim to determine whether homeopathy is effective in improving perceived health, well being and quality of life in the 55+ age group was achieved in this sample of the population. Homeopathy was defined as a complex intervention involving the remedy, the therapeutic relationship and self care. 20 participants aged 55+ took part in the study. 19 received all aspects of the treatment and one participant omitted the homeopathic remedy. 18 participants reported definite or limited improvement in health and well being which they attributed to the treatment. There was no evidence that behaviour relating to self care changed as a result of taking part in this study. There was no clear link between beliefs about homeopathy and the outcome of treatment. Participants who experienced improvements in health during this study were clear in stating their view that homeopathic treatment had made a difference to their health and well being.

As well as using mixed methodology for measuring outcomes in this study, specific questions were asked about different types of health problems. Changes in physical symptoms were an important measure of outcomes of treatment. Participants were able to quantify changes such as improvements in quality of sleep, or identify evidence of increased mobility as they experienced less pain. The physical symptoms that improved were largely common to the 55+ age group, such as joint pain, digestive disturbances and problems with sleep or appetite.

Emotional symptoms are more difficult to measure but participants were clear about changes in the way they felt as a result of homeopathic treatment. Individuals described themselves as calmer, more resilient, having increased energy and motivation. Additionally they described positive changes in their perceptions of life experiences, particularly those which made them anxious or aroused strong emotions. Participants who experienced improvements in emotional well being were able to recognise a change in

themselves and the return of familiar positive feelings that had been lost as a result of health issues.

The aim of this study was not to reduce the use of conventional medication, although the issues associated with the use of pharmaceutical drugs were explored in section 1.1.2 *The cost of health problems in the 55+ age group*. The MYMOP questionnaire asked participants to state if it was important to them to avoid or reduce the use of pharmaceutical medication and almost half of the participants said that it was very important. By the end of the study five participants had reduced their use of medication for the symptoms identified in MYMOP. Although this is a small number, it may be an indication that further research would reveal the potential for homeopathic treatment to cut the financial cost of medicines and allow individuals more choice about use of medication.

An additional marker that participants valued homeopathic treatment was their attendance at appointments. All participants attended all appointments. It is unusual in research studies to get 100% attendance at consultations and this may be an indicator that participants were gaining something valuable from the treatment process. Some of the participants said that although they were committed to the research, if they had not liked coming for appointments they would have found an excuse not to attend.

This study was not designed to explore the mechanism of action of homeopathic remedies, but it is important to consider whether the outcomes achieved in this study were related to the homeopathic remedy rather than other aspects of treatment common to other therapies. 18 of the 19 participants who took the remedy believed that there was evidence that the homeopathic remedy had contributed to changes in their health. Eight of these participants believed that changes occurred as a result of taking the remedy and the interaction with the homeopath. Eight participants also stated that their beliefs about health and healing were not a factor in improvements to their health. Participants were also asked about the impact of self care on changes to their health and there was no clear

evidence in their responses that self care had made any difference to the outcomes of treatment. Their evidence confirmed that the homeopathic remedy had a dynamic effect apparently unrelated to the other aspects of treatment, and also unrelated to any other experience of therapeutic interventions.

## 5.2 COMMON THEMES IN RESEARCH EVIDENCE

It was difficult to separate the outcomes and the themes in this study as the themes that emerged in discussion with participants were closely connected to the outcomes. This was most obvious in their views about the contribution of different aspects of the homeopathic treatment process to changes in their health and well being. There were also common themes which related to the type of life experiences and health issues experienced by the 55+ age group, and the difficulty in resolving these issues using conventional health care.

The key themes that emerged related to:

- ❑ the outcomes from homeopathic treatment, both in terms of changes in physical and emotional well being, and the evidence of the homeopathic remedy working
- ❑ the value of holistic health care methods which take account of the history of the individual, as well as their physical and emotional needs
- ❑ the value of the therapeutic relationship in providing an opportunity for individuals to review their own stories and make connections between past and present experiences, possibly leading to a more enlightened view of their situation and perceptions that enhance health

The themes which were more difficult to express in terms of outcomes were those which were related to the value placed on different aspects of the treatment process. The experience of talking about life experiences and health issues was valued by participants and regarded as a reflective opportunity to make connections, and to review relationships and deeply felt emotions. The homeopathic interview with its focus on individual stories and individual remedies is worthy of further consideration as a valuable approach to healthcare.

The relationship with the homeopath was valued for the non judgemental acceptance of participants' stories. The process of treatment for some was described as a 'journey' which increased self realization and resilience, and in some cases led to an ontological change in perceptions about self and healing. Participants valued the opportunity to take part in a research project and showed strong commitment to honest evaluation of their experience of homeopathic treatment. The professionalism of the homeopath/researcher was also valued and this was expressed in terms of trust, openness and caring. Practical considerations such as the calm venue were also regarded as part of this professional approach. Despite the difficulty in measuring the importance of these themes, they do give some insight into the specific aspects of health care that were valued by this research cohort and potentially the 55+ age group generally.

### 5.3 CHOSEN RESEARCH METHODOLOGY

The most common approach used in research on homeopathy is to measure the effectiveness of a remedy, or the effectiveness of homeopathy in treating specific symptoms. The aim of this study was to go beyond this familiar approach and consider homeopathy as a complex intervention which might be useful in an age group where health problems are more common. Researching a complex intervention presents specific problems in terms of choosing methodology and carrying out the research. The individualised nature of homeopathic treatment means that non-specific effects of treatment may have an impact on outcomes of the study and are more difficult to measure. By using mixed methodology in this study it was hoped that some of the difficulties in researching homeopathy would be overcome.

The pragmatic approach chosen for this research takes account of both biased and unbiased perspectives and combines different methods of data collection. This provided an opportunity to gain some objectivity as well as detail about participant experiences. In general, this seems to have worked well in this study. There are strong connections between the data collected using different methods, and these connections relate to both participant experiences and time points for collecting data. Participants were required to report on their perception of changes in their health in different ways and the coherence of their responses provides strong evidence of the positive effects of homeopathic treatment.

The potential bias involved in the practitioner carrying out the research is a possible limitation of this study, but the trust gained through the practitioner interaction with participants may have led to more openness in evaluating the treatment process for research purposes. Participants also stated very clearly that their views were honest and not influenced by the homeopath/researcher role. By acknowledging the potential for bias, it was hoped that any effects from this dual role would be minimised.

## 5.4 RESEARCH INTO THE EFFECTIVENESS OF HOMEOPATHY

The history of homeopathic research is one of conflict and debate. The focus of this debate is the lack of understanding of the mechanism of action of the homeopathic remedy. Some critics of homeopathy simply dismiss it as implausible and therefore unworthy of consideration, whereas others look for different explanations for positive outcomes in research studies, such as the placebo effect or the therapeutic relationship with the homeopath. Shang et al (2005) conclude that placebo-controlled trials of homeopathy should be replaced by research which focuses on the context of health care needs and the place of homeopathy in the health care system. The focus of this study has been on context and healing, and the value of homeopathic treatment to the participants in the study.

This study found evidence that homeopathy as a complex intervention was effective in improving perceived health and well being in participants in this study in the 55+ age group. The participants identified the different ways in which they experienced the treatment including a strong focus on the effects of the homeopathic remedy. Their observations were consistent with the theory and philosophy of classical homeopathy on which their treatment was based.

It was a privilege to work with the participants in this study and to share different experiences of self discovery and healing. This shared journey was a powerful and moving experience. The participants' views on the experience are important indicators of what can be achieved through homeopathic treatment, both the prescription of a remedy and the insights gained through the process of sharing their story. There are also indicators of the health care needs of the 55+ age group, which involve more than treatment of symptoms. They relate to the need to make sense of past experiences and make connections between those experiences, emotional reactions and health issues. The experiences of the participants in this study seem to have been truly holistic. Although elements of the treatment can be identified, it was the complexity of the intervention that

seemed to meet the complex needs of the individuals who took part in the study. This is summed up by the following quotation from one of the participants during the interview at the end of the final consultation.

“I was interested in participating in this, partly because it was about the well being of older and I’m involved in other things relative to older people so I would say that it’s a very pleasant and easy process, very participative which I like, kind of intrigued by the more the remedy is diluted the stronger it is. I can’t fathom that out but I know that’s the case. The initial consultation I would say was terribly thorough and for me it brought up all kinds of things I thought I’d forgotten” (P13 L26-31)

It is common to conclude a research study by stating that further research is required. There have already been many studies of the efficacy of homeopathy, focusing on specific symptoms and illnesses. The focus of this research on homeopathy as a complex intervention, the 55+ age group and the use of mixed methodology could be valuable subjects for future research.

Society as a whole has an interest in the well being of the 55+ age group and this study reveals important issues for this age group in terms of preferences in health care and potential benefits of a more holistic approach. These include the value of telling a life story, evaluating past experiences and sharing thoughts and feelings in a non-judgemental relationship. These findings are likely to be of interest to health care providers for this age group and publication of this information could provide an interesting perspective on health care for the 55+ age group.

Homeopathy has been explored in this study as a complex intervention and this is a topic for further consideration. Although participants clearly attributed changes in health and well being to the homeopathic remedy, they also valued the process of treatment and reflected on the complex nature of any healing process. The purpose of any publication of outcomes from this study should be to inform other homeopaths and researchers of the potential for improving health and well being in the 55+ age group, highlighting the complexity of the issues involved. To avoid losing this key point, the focus of any



publication should be on the process of research and the complexity of the experience of the participants, rather than just the outcomes.

Additionally the research methodology used in this study is likely to be of interest to other researchers in the CAM field. The mixed methodology chosen has not yet been widely used in CAM research. The benefits of the approach used in this study should be of interest to future researchers in this field.

Classifying homeopathy as a complex intervention introduces a new dimension to research possibilities. Considering the use of homeopathy for an ageing population also takes account of the needs of a growing section of the population who face a period in their lives which may be limited by concerns about health. Participants in this study were clear that the process of homeopathic treatment was valuable and had a positive effect. More evidence to support their view of the experience would help to confirm its value for a wider population. The research methods used in this study have placed a strong emphasis on the participants' views, so it is appropriate to end with these words about homeopathy from one of the participants:

“it combines the healing experience with...reflection and stimulation and thoughtfulness and it's very good” (P18 L33)

## REFERENCES

Adams P (2009) Where is homeopathy going? *The Homeopath* Summer 2009, 28:1 The Journal of the Society of Homeopaths

Baker A (2001) *The sceptics revisit memory of water research* Friends of Homeopathy No 21 Autumn 2001

Bakewell J (2006) QMUC/Royal Bank of Scotland Centre for the Older Person's Agenda (COPA) Lecture *The View from Here* 19 October 2006 Surgeon's Hall, Edinburgh

Banjerjea S K (2007) Pathology and Homeopathy *The Homeopath* Spring 2007, 25:4 The Society of Homeopaths

Barker M, O'Hanlon A, McGee H M, Hickey A, Conroy R N (2007) Cross-sectional validation of the Aging Perceptions Questionnaire: a multidimensional instrument for assessing self-perceptions of aging *BMC Geriatrics* 2007, 7:9  
[www.biomedcentral.com/1471-2318/7/9](http://www.biomedcentral.com/1471-2318/7/9) [Accessed 1 May 2007]

Barker M (1990) *LM Potencies* Sheringham, The Homeopathic Supply Company

Beaglehole R, Ebrahim S, Reddy S, Voute J, Leader S (2007) Prevention of chronic diseases: a call to action *The Lancet* Vol 370 December 22/29, 2007

Bedi R P, Davis M D, Williams M (2005) Critical incidents in the formation of the therapeutic alliance from the client's perspective *Psychotherapy: Theory, Research, Practice, Training* 42, pp 311-323

Bell J, Winter-Jones C (2007) Homeopathy under fire *bma news* (British Medical Association) Saturday November 3, 2007, pp 6 – 7

Bellavite P, Ortolani R, Conforti A (2006) Immunology and homeopathy. 3. Experimental studies on animal models *Evidence-based Complementary and Alternative Medicine* Volume 3, Number 2 pp 171-186  
[www.oxfordjournals.org/cgi/content/full/3/2/171](http://www.oxfordjournals.org/cgi/content/full/3/2/171) [Accessed 27 December 2006]

Bellavite P, Ortolani R, Pontarollo F, Piasere V, Benato G, Conforti A (2006) Immunology and homeopathy. 4. Clinical Studies - Part 2 *eCAM* 2006;3(4)397-409  
doi:10.1093/ecam/ne1046 <http://ecam.oxfordjournals.org/content/vol3/issue4/index.dtl>  
[Accessed 31 July 2006]

Bellavite P, Ortolani R, Pontarollo F, Piasere V, Benato G, Conforti A (2006) Immunology and homeopathy. 5. The Rationale of the 'Simile' *eCAM* 2007; 4(2)149-163 doi:10.1093/ecam/ne1117 <http://ecam.oxfordjournals.org/content/vol4/issue2/index.dtl> [Accessed 7 February 2007]

Bhatia M (2005) Regulating Homeopathy Medicines *Homeopathy 4 Everyone* December 2005 <http://www.hpathy.com/ezone/editorial/2005Dec.asp> [Accessed 8 July 2009]

Bhatia M (2007) Is Homeopathy Bleeding to Death?? *Homeopathy 4 Everyone* e-mail to homeopaths [Accessed 10 November 2007]

BMA (2007) *Better health, better care: BMA Scotland consultation response* [http://www.bma.org.uk/healthcare\\_policy/responses\\_consultations/BHBCresponse.jsp](http://www.bma.org.uk/healthcare_policy/responses_consultations/BHBCresponse.jsp) [Accessed 19 December 2009]

BMA Health Policy and Economic Research Unit (2009) *Factors capable of influencing an increase in GP referral rates to secondary care (England only)* [http://www.bma.org.uk/images/refrates\\_tcm41-186413.pdf](http://www.bma.org.uk/images/refrates_tcm41-186413.pdf) [Accessed 19 December 2009]

BMA (2010) Data from Parliament on early day motions: EDM284A1 *BMA Annual Representative Meeting Motions on Homeopathy* <http://www.edms.org.uk/edms/2010-2011/284A1.htm> [Accessed 5 July 2010]

BMJ Clinical Evidence website <http://clinicalevidence.com/ceweb/about/knowledge/jsp> [Accessed 9 October 2007]

Born G, Baum M, Colquhoun D, Ernst E, Garrow J, Rose L, Tallis R, Thornton H (2007) Letter calling for homeopathy boycott 23 May 2007 *The Times newspaper* [http://www.timesonline.co.uk/tol/life\\_and\\_style/health/article1827553.ece](http://www.timesonline.co.uk/tol/life_and_style/health/article1827553.ece) [Accessed 11 July 2010]

Bousta D, Soulimani R, Jarmouni I, Belon P, Falla J, Froment N, Younos C (2001) Neurotropic, immunological and gastric effects of low doses of *Atropa belladonna*, *Gelsemium sempervirens* and *Poumon histamine* in stressed mice *Journal of Ethnopharmacology* Volume 74 Issue 3, March 2001 pp 205-215 [http://www.sciencedirect.com/science?\\_ob=ArticleURL&\\_udi=B6T8D-42M78MM-2&\\_user=10&\\_rdoc=1&\\_fmt=&\\_orig=search&\\_sort=d&\\_docanchor=&\\_view=c&\\_searchStrId=1142167397&\\_rerunOrigin=scholar.google&\\_acct=C000050221&\\_version=1&\\_urlVersion=0&\\_userid=10&md5=82b256f2a3e71268b1a11397e464b62a](http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6T8D-42M78MM-2&_user=10&_rdoc=1&_fmt=&_orig=search&_sort=d&_docanchor=&_view=c&_searchStrId=1142167397&_rerunOrigin=scholar.google&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=82b256f2a3e71268b1a11397e464b62a) [Accessed 20 December 2009]

Bowling A, Bond M, Jenkinson C, Lamping D L (1999) Short Form 36 (SF-36) Health Survey questionnaire: which normative data should be used? Comparisons between the norms provided by the Omnibus Survey in Britain, the Health Survey for England and the Oxford Healthy Life Survey *Journal of Public Health* 1999 Vol 21, No 3 pp 255-270

Bowling, Ann (2001) *Measuring Disease* Buckingham, Open University

Boulderstone J (2009) *Explain Homeopathy* [www.explainhomeopathy.com](http://www.explainhomeopathy.com) e-mail to homeopaths [Accessed 8 September 2009]

Bradford-Hill A (1965) The Environment and Disease: Association or Causation? *Proceedings of the Royal Society of Medicine* 58, pp 295-300 <http://www.edwardtufte.com/tufte/hill> [Accessed 8 August 2010]

Brecher E M (1996) *Love, Sex and Ageing* London, Thorsons

Bridger M (2003) Case Mapping – the relationship of remedies in practice *The Homeopath* (2003) 88, pp 16-20 The Society of Homeopaths

British Homeopathic Association (2009) Memorandum submitted by The British Homeopathic Association HO12 to the Science and Technology Committee UK Parliament <http://www.publications.parliament.uk/pa/cm200910/cmselect/cmsctech/memo/homeopathy/ucm1202.pdf> [Accessed 15 July 2010]

British Medical Association, the Royal Pharmaceutical Society of Great Britain (March 2002) *British National Formulary* Pharmaceutical Press

Butler R N, Miller R A, Perry D, Carnes B A, Franklin Williams T, Cassel C, Brody J, Bernard M A, Partridge L, Kirkwood T, Martin G M, Jay Olshansky S (2008) New model of health promotion and disease prevention for the 21<sup>st</sup> century *BMJ* 2008; 337:a399 doi:10.1136/bmj.a399 [http://www.bmj.com/cgi/content/full/337/jul08\\_3/a399?maxtoshow=&hits=10&RESULTFORMAT=1&author1=butler&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=date&volume=337&fdate=//&resourcectype=HWCIT](http://www.bmj.com/cgi/content/full/337/jul08_3/a399?maxtoshow=&hits=10&RESULTFORMAT=1&author1=butler&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=date&volume=337&fdate=//&resourcectype=HWCIT) [Accessed 1 July 2009]

Campbell M, Fitzpatrick R, Haines A, Kinmonth A L, Sandercock P, Spiegelhalter D, Tyrer P (2000) Framework for design and evaluation of complex interventions to improve health *BMJ* 2000; 321: 694-696 <http://www.bmj.com/cgi/content/full/321/7262/694?maxtoshow=&hits=10&RESULTFORMAT=1&author1=Campbell&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=date&volume=321&fdate=1/1/1981&resourcectype=HWCIT> [Accessed 16 September 2009]

Cant S, Sharma U (1996) *Complementary and Alternative Medicines Knowledge in Practice* London, Free Association Books Ltd

Capra F (2005) *Wholeness and Health* chapter 14 *Perspectives on Complementary and Alternative Medicine: A Reader* Editors: Lee-Treweek G, Heller T, Spurr S, MacQueen H, Katz J (2005) Abingdon Oxon, Routledge

Castro M (1990) *The Complete Homeopathy Handbook* London, Papermac (Pan Macmillan Publishers Ltd)

Chappell P (1994) *Emotional Healing with Homeopathy* Shaftesbury, Element Books Ltd

Charmaz K (2006) *Constructing Grounded Theory* London, Sage Publications Ltd

Chatfield, K In Pursuit of Evidence *The Homeopath* Winter 2006, 25:3 The Society of Homeopaths

Chatfield K, Viksveen P (2007) *An Overview of Positive Homeopathy Research and Surveys*, ENHR, March 2007 The Society of Homeopaths website <http://www.homeopathy-soh.org/> [Accessed 27 January 2009]

Christie E A, Ward A T (1996) Report on NHS practice-based homeopathy project. Analysis of effectiveness and cost of homeopathic treatment within a GP practice at St. Margaret's Surgery, Bradford on Avon, Wilts September 1996 *The Society of Homeopaths* ISBN 1 901262 006

Christie B (2006) Guidelines on treating risk factors turn healthy people into patients *British Medical Journal* 2006;333:988 doi:10.1136/bmj.39024.405602.DB [www.bmj.com/cgi/content/full/333/7576/988](http://www.bmj.com/cgi/content/full/333/7576/988) [Accessed 11 November 2006]

Close Stuart (reprint 1990) *The Genius of Homeopathy* India, B Jain Publishers Ltd

Clover A (1989) *Homeopathy Reconsidered* Lymington, The Spartan Press Ltd

Clover A (2000) Patient benefit survey: Tunbridge Wells Homeopathic Hospital *British Homeopathic Journal* Vol 89, Issue 2, pp 68-72 [http://www.sciencedirect.com/science?\\_ob=ArticleURL&\\_udi=B8CWK-4MDGN8C-3&\\_user=10&\\_coverDate=04%2F30%2F2000&\\_rdoc=1&\\_fmt=high&\\_orig=search&\\_sort=d&\\_docanchor=&\\_view=c&\\_searchStrId=1403683337&\\_rerunOrigin=google&\\_acct=C000050221&\\_version=1&\\_urlVersion=0&\\_userid=10&md5=d6cab4f3e3d3f48a0684f1d165284801](http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B8CWK-4MDGN8C-3&_user=10&_coverDate=04%2F30%2F2000&_rdoc=1&_fmt=high&_orig=search&_sort=d&_docanchor=&_view=c&_searchStrId=1403683337&_rerunOrigin=google&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=d6cab4f3e3d3f48a0684f1d165284801) [Accessed 18 July 2010]

Cochrane Reviews (2009) *The Cochrane Collaboration* The Cochrane Library  
[http://search.cochrane.org/search?q=homeopathy&restrict=review+abstracts&scso\\_cochrane\\_org=this+site&scso\\_review\\_abstracts=review+abstracts&scso\\_evidence\\_aid=evidence+aid&scso\\_colloquia\\_abstracts=colloquia+abstracts&scso\\_newsletters=newsletters&ie=&site=my+collection&output=xml+no+dtd&client=my+collection&lr=&proxystylesheet=http%3A%2F%2Fwww.cochrane.org%2Fsearch%2Fgoogle\\_mini\\_xsl%2Fcochrane\\_org.xsl&oe=&filter=0&sub\\_site\\_name=Cochrane+Reviews+search](http://search.cochrane.org/search?q=homeopathy&restrict=review+abstracts&scso_cochrane_org=this+site&scso_review_abstracts=review+abstracts&scso_evidence_aid=evidence+aid&scso_colloquia_abstracts=colloquia+abstracts&scso_newsletters=newsletters&ie=&site=my+collection&output=xml+no+dtd&client=my+collection&lr=&proxystylesheet=http%3A%2F%2Fwww.cochrane.org%2Fsearch%2Fgoogle_mini_xsl%2Fcochrane_org.xsl&oe=&filter=0&sub_site_name=Cochrane+Reviews+search) [Accessed 27 January 2009]

Cochrane Reviews (2010) *The Cochrane Collaboration* The Cochrane Library  
<http://www2.cochrane.org/reviews/en/ab004845.html> [7 July 2010]

Cohen D (2009) Drugs agency grants its first licence to homeopathic product *BMJ* 2009;338:b2055 [http://www.bmj.com/cgi/content/full/may20\\_1/b2055](http://www.bmj.com/cgi/content/full/may20_1/b2055) [Accessed 22 May 2009]

Cohen D, Kinney P L (2007) Ader R (Ed) *Psychoneuroimmunology* Fourth Edition, Volume 1, Chapter 8, London, Elsevier Academic Press

Cohen I, Manion L, Morrison K (2000) *Research Methods in Education* New York, Rutledge Falmer

Collerton J, Barrass K, Bond J, Eccles M, Jagger C, James O, Martin-Ruiz C, Robinson L, von Zglinicki T, Kirkwood T (2007) The Newcastle 85+ study: biological, clinical and psychosocial factors associated with health ageing: study protocol *BMC Geriatrics* 2007, 7:14 doi:10.1186/1471-2318-7-14 [www.biomedcentral.com/1471-2318/7/14](http://www.biomedcentral.com/1471-2318/7/14) [Accessed 2 July 2007]

Complementary Medicine Research Group, University of York (2010) Memorandum HO 24 submitted to the Commons Select Committee on Science and Technology  
<http://www.publications.parliament.uk/pa/cm200910/cmselect/cmsctech/memo/homeopathy/ucm2402.htm> [Accessed 4 August 2010]

Conforti A, Bellavite P, Bertani S, Chiarotti F, Menniti-Ippolito F, Raschetti R (2007) Rat models of acute inflammation: a randomized controlled study on the effects of homeopathic remedies *BMC Complementary and Alternative Medicine* 2007, 7:1 doi:10.1186/1472-6882-7-1 [www.biomedcentral.com/1472-6882/7/1](http://www.biomedcentral.com/1472-6882/7/1) [Accessed 20 January 2007]

Contopoulos-Ioannidis D G, Karvouni A, Kouri I, Ioannidis J P A (2009) Reporting and interpretation of SF-36 outcomes in randomized trials: systematic review *BMJ* 2009;338:a3006 doi:10.1136/bmj.a3006  
[http://www.bmj.com/cgi/content/full/338/jan12\\_1/3006](http://www.bmj.com/cgi/content/full/338/jan12_1/3006) [Accessed 13 January 2009]

- Cooper E L (2007) The Immune System and Complementary and Alternative Medicine *eCAM* 2007;4(SI) 5-8 doi:10.1093/ecam/nem093  
[http://ecam.oxfordjournals.org/cgi/content/full/4/suppl\\_1/5](http://ecam.oxfordjournals.org/cgi/content/full/4/suppl_1/5) [Accessed 4 July 2007]
- Coulter H L (1980) *Homeopathic Science and Modern Medicine* American Institute of Homeopathy
- Creswell J W (2009) *Research Design* London, Sage Publications Ltd
- Creswell J W, Piano Clark V L (2008) *Designing and Conducting Mixed Methods Research* London, Sage Publications Ltd
- Damoiseau R A M J, van Balen F A M, Hoes A W, Verheij T J M, de Melker R A (2000) Primary care based randomised double blind trial of amoxicillin versus placebo for acute otitis media in children aged under 2 years *BMJ* 2000, 320: 350-354  
<http://www.bmj.com/cgi/content/full/320/7231/350?maxtoshow=&hits=10&RESULTFORMAT=1&title=otitis+media&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=date&volume=320&fdate=1/1/1981&resourcetype=HWCIT> [Accessed 1 July 2009]
- Danciger E (2006) The Wounded Healer *The Homeopath* Autumn 2006, 25:2 The Society of Homeopaths
- Dawson J, Doll H, Fitzpatrick R, Jenkinson C, Carr A J (2010) Research Methods and Reporting - The routine use of patient reported outcome measures in healthcare settings *BMJ* 18 January 2010, doi: 10.1136/bmj.c186  
[http://www.bmj.com/cgi/content/full/340/jan18\\_1/c186](http://www.bmj.com/cgi/content/full/340/jan18_1/c186) [Accessed 26 January 2010]
- Deary I J, Gow A J, Taylor M D, Corley J, Brett C, Wilson V, Campbell H, Whalley L J, Visscher P M, Porteous D J, Starr J M (2007) The Lothian Birth Cohort 1936: a study to examine influences on cognitive ageing from age 11 to age 70 and beyond *BMC Geriatrics* 2007, 7:28 doi:10.1186/1471-2318-7-28  
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2222601/> [Accessed 10 July 2008]
- Degele N (2005) On the margins of everything: doing, performing and staging science in homeopathy *Science, Technology and Human Values* 30(1) pp 111-136
- Dempster A (1998) *Homeopathy within the NHS Evaluation of homeopathic treatment of common mental health problems 1995-1997* included in Chatfield K, Viksveen P (2007) *An Overview of Positive Homeopathy Research and Surveys*, ENHR, March 2007 The Society of Homeopaths website <http://www.homeopathy-soh.org/> [Accessed 27 January 2009]



Di Blasi (2005) *The crack in the biomedical box: the placebo effect* chapter 35 *Perspectives on Complementary and Alternative Medicine: A Reader* Editors: Lee-Treweek G, Heller T, Spurr S, MacQueen H, Katz J (2005) Abingdon Oxon, Routledge

Dilly S A, Finlayson C J and Lakhani S R (1998) *Basic Pathology An Introduction to the Mechanisms of Disease* London, Arnold

Donaghy M (2007) Queen Margaret University Edinburgh Professorial Lecture *Exercise can seriously improve your mental health: fact or fiction?* 21 February 2007, QMU Edinburgh

Employment Equality (Age) Regulations 2006 Act of Parliament HMSO  
<http://www.opsi.gov.uk/si/si2006/20061031.htm> [Accessed 30 January 2009]

Enderby P (2007) The right methods for the right questions *Scottish NHMAP Research in Practice Conference* Royal College of Physicians, Edinburgh 23 October 2007

Evans J (2006) *Invisible Mending* The Homeopath Winter 2006, 25:3 The Society of Homeopaths

Eyles C, Walker J, Brien S, (2009) Homeopathic Practitioner's Experiences of the Homeopathic Consultation: A Protocol of a Grounded Theory Study *The Journal of Alternative and Complementary Medicine* April 2009, 15(4): 347-352 doi:10.1089/acm.2008.0105.  
<http://www.liebertonline.com/doi/abs/10.1089/acm.2008.0105> [Accessed 29 May 2010]

Featherstone C, Forsyth L (1997) *Medical Marriage* Findhorn Press

ERPHO (2009) *Research trends in GP consultation rates 1995/96 to 2007/08*  
<http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/general-practice/qresearch-report-on-trends-in-consultation-rates-in-general-practices-1995-2008>  
[Accessed 19 December 2009]

European Network for Homeopathy (2007) *An Overview of Positive Homeopathy Research and Surveys* The European Network of Homeopathy Researchers March 2007  
<http://www.homeopathy-soh.org/for-members/research/> [Accessed 27 January 2009]

Fiatarone M A, Marks E C, Ryan N D, Meredith C N, Lipsitz L A and Evans W J (1990) High-intensity strength training in nonagenarians. Effects on skeletal muscle *Journal of the American Medical Association* 263,3029-3034  
<http://jama.amaassn.org/cgi/reprint/263/22/3029?maxtoshow=&hits=10&RESULTFOR=MAT=&fulltext=fiatarone+1990&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT>  
[Accessed 12 April 2010]



Fisher P (2007) Open letter, closed minds *Guardian* 23 May 2007 [www.commentisfree.guardian.co.uk/peter\\_fisher/2007/05/open\\_letter\\_closed\\_minds](http://www.commentisfree.guardian.co.uk/peter_fisher/2007/05/open_letter_closed_minds) [Accessed 26 May 2007]

Fønnebø V, Grimsgaard S, Walach H, Ritenbaugh C, Norhelm A J, MacPherson H, Lewith G, Launsø L, Koithan M, Falkenberg T, Boon H, Aickin M (2007) Researching complementary and alternative treatments – the gatekeepers are not at home *BMC Medical Research Methodology* 2007, 7:7 [www.biomedcentral.com/1471-2288/7/7](http://www.biomedcentral.com/1471-2288/7/7) [Accessed 23 February 2007]

Franco O H, Kirkwood T B L, Powell J R, Catt M, Goodwin J, Ordovas J M, van der Ouderaa F (2007) Ten commandments for the future of ageing research in the UK: a vision for action *BMC Geriatrics* 2007, 7:10 doi:10.1186/1471-2318-7-10 [www.biomedcentral.com/1471-2318/7/140](http://www.biomedcentral.com/1471-2318/7/140) [Accessed 2 July 2007]

Franck L, Chantler C, Dixon M (2007) Should NICE evaluate complementary and alternative medicine? *BMJ* 2007;334-506 [www.bmj.com/cgi/content/full/334/7592/506](http://www.bmj.com/cgi/content/full/334/7592/506) [Accessed 10 March 2007]

Fraser P (1998) The Proving of Homeopathic Remedies *Positive Health* July 1998

Friedan Betty (1993) *The Fountain of Age* New York, Simon & Schuster

Friedrich M J (2002) Biological Secrets of Exceptional Old Age *American Medical Association JAMA* November 13, 2002-Vol 288, No 18, 2247-2256 <http://jama.ama-assn.org/cgi/content/extract/288/18/2247?maxtoshow=&hits=10&RESULTFORMAT=1&author1=friedrich&title=biological&andorexacttitle=and&andorexacttitleabs=and&fulltext=2002+Friedrich&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&volume=288&resourcetype=HWCIT> [Accessed 10 July 2009]

Fulder S (1996) *Handbook of Alternative and Complementary Medicine* Oxford University Press

Furnham A, Smith C (1988) Choosing Alternative Medicine: A comparison of the beliefs of patients visiting a general practitioner and a homeopath *Social Science and Medicine* 1988, 26: 685-689

Garratt A (2009) Patient reported outcome measures in trials *BMJ* 2009;338:a2597 doi:10.1136/bmj.a2597 [http://www.bmj.com/cgi/content/full/338/jan12\\_1/a2597](http://www.bmj.com/cgi/content/full/338/jan12_1/a2597) [Accessed 13 January 2009]

Garratt A, Schmidt L, Mackintosh A, Fitzpatrick R (2002) Quality of life measurement; bibliographic study of patient assessed health outcome measures *BMJ* 2002;324:1417 (15 June) <http://www.bmj.com/cgi/content/full/324/7351/1471> [Accessed 13 January 2009]

Ghaye T, Lillyman S (1997) *Learning Journals and Critical Incidents: Reflective Practice for Healthcare Professionals* London, Mark and Allen Publishing

Gillett G R (2006) Medical science, culture and truth Philosophy, *Ethics and Humanities in Medicine* 2006, 1:13 doi:10.1186/1747-5341-1-13 [www.peh-med.com/content/1/1/13](http://www.peh-med.com/content/1/1/13) [Accessed 20 December 2006]

Giorgi A, Giorgi B (2008) *Phenomenology* in Smith J (ed) *Qualitative Psychology* London, Sage

Godlee F (2008) Doctors and the drug industry *BMJ* 2008;336 (5 January), doi:10.1136/bmj.39444.472708.47 [www.bmj.com/cgi/content/full/336/7634/0](http://www.bmj.com/cgi/content/full/336/7634/0) [Accessed 7 January 2008]

Greenhalgh T (2001) *How to Read a Paper* London, BMJ

Greenhalgh T, Hurwitz B (1998) *Narrative Based Medicine* London, BMJ Books

Greenhalgh T, Donald A (2000) *Evidence Based Health Care Workbook* London, BMJ Books

Grimes M (2009) Research supporting homeopathy *Health News* 13 February 2009 <http://www.healthnews.com/blogs/melanie-grimes/natural-health/alternative-medicine/research-supporting-homeopathy/> [Accessed 1 March 2009]

Grimley Evans J (1995) Evidence based and evidence biased medicine *Age Ageing* 1995; 24:461-4 <http://ageing.oxfordjournals.org/cgi/reprint/24/6/461> [Accessed 1 July 2008]

Groves T (2008) Enhancing the quality and transparency of health research *BMJ* 2008;337:a718 doi:10.1136/bmj.a718 [http://www.bmj.com/cgi/content/full/337/oct22\\_1/a2201?maxtoshow=&hits=10&RESULTFORMAT=1&author1=groves&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=date&volume=337&fdate=1/1/1981&resourcetype=HWCIT](http://www.bmj.com/cgi/content/full/337/oct22_1/a2201?maxtoshow=&hits=10&RESULTFORMAT=1&author1=groves&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=date&volume=337&fdate=1/1/1981&resourcetype=HWCIT) [Accessed 10 July 2008]

Hahnemann Samuel (1810 reprinted 1996) *The Organon of Medicine* India, B Jain Publishers Ltd

Hagger M S, Orbell S (2003) A meta-analytic review of the common-sense model of illness representation *Psychology and Health* 2003, 18(2): 141-184

Haidvogel M, Riley D S, Heger M, Brien S, Jong M C, Fisher M, Lewith G T, Jansen G, Thurneysen A E (2007) Homeopathic and conventional treatment for acute respiratory and ear complaints: a comparative study of outcomes in the primary care setting *BMC Complementary and Alternative Medicine* 2007, 7:7 [www.biomedcentral.com/1472-6882/7/7](http://www.biomedcentral.com/1472-6882/7/7) [Accessed 10 March 2007]

Hamilton H J, Gallagher P F, O'Mahoney D (2009) Inappropriate prescribing and adverse drug events in older people *BMC Geriatrics* 2009, 9:5 doi:10.1186/1471-2318-9-5 <http://www.biomedcentral.com/1471-2318/9/5> [Accessed 28 January 2009]

Hamre H J, Witt C M, Glockmann A, Ziegler R, Willich S N, Kiene H (2007) Anthroposophic medical therapy in chronic disease: a four year prospective cohort study *BMC Complementary and Alternative Medicine* 2007, 7:10 doi:10.1186/1472-6882-7-10 [www.biomedcentral.com/1472-6882/7/10](http://www.biomedcentral.com/1472-6882/7/10) [Accessed 25 April 2007]

Hayes V, Morris J, Wolfe C, Morgan M (1995) The SF-36 Health Survey Questionnaire: Is it Suitable for use with Older Adults? *Age and Ageing* 1995;24:120-125 <http://ageing.oxfordjournals.org/cgi/reprint/24/2/120> [Accessed 1 July 2008]

Hayfield R (1993) *Homeopathy for Common Ailments* London, Gaia Books Ltd

Heirs M (2009) Further research required *The Homeopath* Summer 2009, 28:1 The Journal of the Society of Homeopaths

Heiligers P J M, de Groot J, Koster D, van Dulmen S (2010) Diagnosis and visit length in complementary and mainstream medicine *BMC Complementary and Alternative Medicine* 2010, 10:3 doi:10.1186/1472-6882-10-3 <http://www.biomedcentral.com/1472-6882/10/3> [Accessed 30 January 2010]

Herzlich C and Pierret J (1986) *Illness and self in society* translated by Elborg Forster, Baltimore, John Hopkins University

Holmes C A V (1998) *There is no such thing as a therapist* London, H.Karnac (Books) Ltd

Homeopathician July-Sept 1916 *James Tyler Kent: Physician-Teacher-Author* Pittsburgh, Pa, Homeopathician Publishing Co

Homeopathy: the realistic alternative (1993) *Materia Medica Communications* East Sussex [video:VHS]

Hope R A, Longmore J M, McManus S K, Wood-Allan C A (2000) *Oxford Handbook of Clinical Medicine* Oxford University Press

Horowitz S (2008) Optimal Healing Environments *Alternative and Complementary Therapies* doi:10.1089/act.2008.14607 Mary Ann Liebert, Inc. Vol 14 No 6 December 2008 <http://www.liebertonline.com/doi/abs/10.1089/act.2008.14607> [Accessed 12 August 2010]

House of Commons Science and Technology Committee (2010) *Evidence check 2: homeopathy* HC 45 Fourth Report of Session 2009-10, 22 February 2010 <http://www.parliament.uk/business/committees/committees-archive/science-technology/s-t-homeopathy-inquiry/> [Accessed 16 June 2010]

House of Commons (2010) *Government Response to the Science and Technology Committee report 'Evidence Check 2: Homeopathy'* Presented to Parliament by the Secretary of State for Health by Command of Her Majesty July 2010 [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_117811.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117811.pdf) [Accessed 1 August 2010]

House of Lords Select Committee on Science & Technology, Session 1999-2000 Sixth Report *Complementary and Alternative Medicine* <http://www.publications.parliament.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm> [Accessed 4 June 2010]

Hurley J (2005) Treating the Elderly *The Homeopath* (Summer 2005) 24.1, 26-27 The Society of Homeopaths

Jagger C, Gillies C, Moscone F, Cambois E, Van Oyen H, Nusselder W, Robine J M (2008) Inequalities in healthy life years in the 25 countries of the European Union in 2005: a cross-national meta-regression analysis *The Lancet* Volume 372, Issue 9656, pp 2124-2131, 20 December 2008 doi:10.1016/S0140-6736(08)61584-9 [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(08\)61594-9/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)61594-9/fulltext) [Accessed 15 January 2009]

Jansen J P (2006) The Placebo Effect: Pleasing for Homeopathy Research? *The Homeopath* Winter 2006, 25:3 The Society of Homeopaths

Jenkins C (1996) MYMOP, a patient generated measure of outcomes *BMJ* 1996;313:626 (September) <http://bmj.bmjournals.com/cgi/content/full/313/7057/626> [Accessed 30 October 2006]

Jenkinson C, Coulter A, Wright L (1993) Short form 36 (SF36) health survey questionnaire: normative data for adults of working age *BMJ* 1993 May 29; 306(6890): 1437-1440

John E, Kosinski M, Keller S (1994) *SF-36 Physical and Mental Health Summary Scales: A User's Manual* Health Assessment Lab

Kaptchuk T J, Kelley J M, Conboy L A, Davis R B, Kerr C E, Jacobson E A, Kirsch I, Schyner R N, Nam B H, Nguyen L T, Park M, Rivers A L, McManus C, Kokkotou E, Drossman D A, Goldman P, Lembo A J (2008) Components of placebo effect: randomized trial in patients with irritable bowel syndrome *BMJ* 2008;336;993-1003 doi:10.1136/bmj.39524.439618.25

<http://www.bmj.com/cgi/content/full/336/7651/999?maxtoshow=&hits=10&RESULTFORMAT=1&author1=Kaptchuk&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=date&volume=336&fdate=1/1/1981&resourcetype=HWCIT> [Accessed 2 May 2008]

Kelly G (1969) *Personal Construct Theory and the Therapeutic Interview* New York, Wiley

Kent James Tyler (1900) *Lectures on Homeopathic Philosophy* India, B Jain Publishers Ltd

Kenton Leslie (1996) *Passage to Power* London, Vermilion

Kenton Leslie (2002) *Age Power* London, Vermilion

Kennedy A, Rogers A, Bower P (2007) Support for self care for patients with chronic diseases *BMJ* 2007;335:968-970 (10 November) doi:10.1136/bmj.39372.540903.94

<http://www.bmj.com/cgi/content/full/335/7627/968?andorexacttitleabs=and&sortspec=date&hits=10&fdate=1%2F1%2F1981&volume=335&author1=Kennedy&andorexacttitle=and&FIRSTINDEX=0&andorexactfulltext=and&resourcetype=HWCIT&searchid=1&RESULTFORMAT=1> [Accessed 10 July 2009]

Kiebzak G M, Pierson L M, Campbell M, Cook J W (2002) Use of the SF36 general health status survey to document health-related quality of life in patients with coronary artery disease: Effect of disease and response to coronary artery bypass graft surgery *Heart & Lung: Journal of Acute & Critical Care* 31(3):207-213, May/June 2002

Kinnear P R and Gray C D (2002) *SPSS for Windows Made Simple* Hove and New York, Psychology Press

Kirsch I, Deacon B J, Huedo-Medina T B, Scoboria A, Moore T J, Johnson B T (2008) Initial Severity and Antidepressant Benefits: A Meta-Analysis of Data Submitted to the Food and Drug Administration *PLoS Med* 5(2): e45. doi:10.1371/journal.pmed.0050045 <http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0050045> [Accessed 15 July 2010]

Kleijnen J, Knipschild P, ter Riet G (1991) Clinical trials of homeopathy *BMJ* 1991 February 9; 302(6772): 316-324 <http://www.bmj.com/cgi/reprint/302/6772/316> [Accessed 5 July 2010]

Kuipers S (2008) Empathy – friend or foe? pros and cons *The Homeopath* Spring 2008, 26:4 The Society of Homeopaths

Larkin M (1999) Centenarians point the way to healthy ageing *The Lancet* Vol 353, March 27 1999

Launsø L (2008) Therapists' effect, assumptions and users' own effort - when people with chronic diseases consult conventional and alternative therapists *Journal of Research in Disease & Society* 2008, **9**: 97-112 [In Danish with English abstract - accessed 18 November 2009]

Lee-Treweek G, Heller T, Spurr S, MacQueen H, Katz J (2005) *Perspectives on Complementary and Alternative Medicine: A Reader* Abingdon Oxon, Routledge

Leigh E (2006) A safer place for patients: learning to improve patient safety Parliamentary Public Accounts Committee Report *British Medical Journal* 2006 333:59

Levy B R, Myers L M, Preventative health behaviors influenced by self-perceptions of aging *Preventative Medicine: An International Journal Devoted to Practice and Theory* 2004, 39(3):625-629

Lewith G, Verhoef M, Koithan M, Zick S M, (2006) *Developing CAM Research Capacity for Complementary Medicine* Evidence-based Complementary and Alternative Medicine Vol 3, Number 2, pp 283-289 Oxford Journals Medicine

Lin M, Ward J E (1998) Reliability of the MOS SF36 health status measure in Australian general practice *Aust Fam Physician* 1998 Jul; 27 Suppl 2:S94-8 <http://www.ncbi.nlm.nih.gov/pubmed/9679363> [Accessed 8 January 2009]

Lipsett A (2008) Homeopathy degree suspended after criticism *The Guardian* Education Supplement 27 August 2008

Lockie A (1989) *The Family Guide to Homeopathy* London, Guild Publishing

Long L, Ernst E (2001) Homeopathic remedies for the treatment of osteoarthritis: a systematic review *Homeopathic Journal* 2001; 90: 37-43

Lyons R A, Perry H M, Littlepage B N C (1994) Evidence for the validity of the Short-form 36 Questionnaire (SF-36) in an Elderly Population *Age and Ageing* 1994;**23**:182-184

Ludtke R, Rutten A L B (2008) The conclusions on the effectiveness of homeopathy highly depend on the set of analyzed trials *Journal of Clinical Epidemiology* 2008 Dec;61(12):1197-204, Epub 2008 Oct 1, doi:10.1016/j.jclinepi.06.015 <http://www.ncbi.nlm.nih.gov/pubmed/18834714> [Accessed 17 January 2009]



Maha N, Shaw A (2007) Academic doctors' views of complementary and alternative medicine (CAM) and its role within the NHS: an exploratory qualitative study *BMC Complementary and Alternative Medicine* 2007, 7:17 doi:10.1186/1472-6882-7-17 [www.biomedcentral.com/1472-6882/7/107](http://www.biomedcentral.com/1472-6882/7/107) [Accessed 1 June 2007]

McDade D (2008) *Evaluation of a CAM Pilot Project in Northern Ireland May 2008* Department of Health, Social Services and Public Safety report [http://www.dhsspsni.gov.uk/final\\_report\\_from\\_smr\\_on\\_the\\_cam\\_pilot\\_project\\_-\\_may\\_2008.pdf](http://www.dhsspsni.gov.uk/final_report_from_smr_on_the_cam_pilot_project_-_may_2008.pdf) [Accessed 14 February 2009]

Macdonald A, Straughn J, Sutton M (2006) *Healthy Life Expectancy Measurement in Scotland* Sessional Meeting Paper for the Faculty of Actuaries Scotland produced by Department of Actuarial Mathematics and Statistics, Heriot-Watt University, Edinburgh [http://www.actuaries.org.uk/\\_data/assets/pdf\\_file/0020/31619/fac\\_sm20060220.pdf](http://www.actuaries.org.uk/_data/assets/pdf_file/0020/31619/fac_sm20060220.pdf) [Accessed 12 April 2010]

MacEoin D (2006) Good Science, Bad Science *The Homeopath* Winter 2006, 25:3 The Society of Homeopaths

McHorney C A, Ware J E Jr, Lu R, Sherbourne J F, Donald C (1994) The MOS 36-Item Short-Form Health Survey (SF-36): III. Tests of Data Quality, Scaling Assumptions, and Reliability Across Diverse Patient Groups. *Medical Care* 32(1):40-66 January 1994 <http://www.lww-medicalcare.com/pt/re/medcare/abstract.00005650-199401000-00004.htm;jsessionid=JkFQJQ5KP19nyTnV2Jt4Gv6Y1NzLs2HF4HfGDKJ2n2gm0dg2TcPN!1329102805!181195628!8091!-1> [Accessed 08 January 2009]

Mangin D, Sweeney K, Heath I (2007) Preventative health care in elderly people needs rethinking *British Medical Journal* 2007;335:285-287

Marian F, Joost K, Saini K D, von Ammon K, Thurneyson A, Busato A (2008) Patient satisfaction and side effects in primary care: an observational study comparing homeopathy and conventional medicine *BMC Complementary and Alternative Medicine* 2008, 8:52 doi:10.1186/1472-6882-8-52 <http://www.biomedcentral.com/1472-6882/8/52> [Accessed 21 January 2009]

Marshall C, Rossman G B (1995) *Designing Qualitative Research* London, Sage Publications Ltd

Martens L, Creswell J W, Piano Clark V L (Ed) (2008) *Designing and Conducting Mixed Methods Research* London, Sage Publications Ltd

Marucha P T, Kiecolt-Glaser J K, Favagehi M (1998) Mucosal Wound Healing is Impaired by Examination Stress *Psychosomatic Medicine* 60:362-365 (1998) <http://www.psychosomaticmedicine.org/cgi/reprint/60/3/362> [Accessed 20 February 2010]

Matthews R (2006) *25 Big Ideas: The science that's changing our world* New York, Oneworld

Medical Research Council (2000) *MRC Framework for the Development and Evaluation of RCTs for Complex Interventions to Improve Health*  
<http://www.mrc.ac.uk/Utilities/Documentrecord/index.htm?d=MRC003372> [Accessed 15 July 2009]

Medical Research Council (2006) *A Framework for Development and Evaluation of RCT's for Complex Interventions to Improve Health* MRC [http://www.european-academy-of-nursing-science.com/wp-content/uploads/2010/01/MRC-II\\_-2008.pdf](http://www.european-academy-of-nursing-science.com/wp-content/uploads/2010/01/MRC-II_-2008.pdf) [Accessed 12 August 2010]

Medical Research Council (2008) *Developing and evaluating complex interventions: new guidance* <http://www.mrc.ac.uk/Utilities/Documentrecord/index.htm?d=MRC004871> [Accessed 15 July 2009]

Meissner K, Distel H, Mitzdorf U (2007) Evidence for placebo effects on physical but not on biochemical outcome parameters : a review of clinical trials *BMC Medicine* 2007, 5:3 [www.biomedcentral.com](http://www.biomedcentral.com) 1741-7015/5/3 [Accessed 20 March 2007]

Milgrom L (2003) Homeopathy and the Quantum World – Why Bother? *The Homeopath* July 2003 No 90 The Society of Homeopaths

Millenson J R (1995) *Mind Matters* Seattle, Eastland Press

Milton J C (2008) Prescribing for older people *BMJ* 2008;336:606-9 doi:10.1136/bmj.39503.424653.80  
<http://www.bmj.com/cgi/content/full/336/7644/606?maxtoshow=&hits=10&RESULTFO&MAT=1&author1=milton&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=date&volume=336&fdate=1/1/1981&resourcetype=HWCIT> [Accessed 20 March 2008]

Mintel Reports (2007) *Complementary Medicines – UK* Mintel International Group Ltd  
<http://www.marketresearch.com/product/display.asp?productid=1486814&SID=35732025-390828401-359312200&curr=GBP&kw=homeopathy&view=toc> [Accessed 18 September 2007]

Mitchell A, Cormack M (2005) *What is distinctive about complementary medicine?* chapter 11 *Perspectives on Complementary and Alternative Medicine: A Reader* Editors: Lee-Treweek G, Heller T, Spurr S, MacQueen H, Katz J (2005) Abingdon Oxon, Routledge

Mitchell G R (1975) *Homeopathy: the first authoritative study of its place in medicine today* London, W H Allen



Mollinger H, Schneider R, Walach H (2009) Homeopathic pathogenetic trials produce specific symptoms different from placebo *Forsch Komplementmed* 2009 April 16(2); 105-10 Epub 2009 April 9 <http://www.ncbi.nlm.nih.gov/pubmed/19420956> [Accessed 9 July 2010]

Morgan D L (2007) Paradigms Lost and Pragmatism Regained *Journal of Mixed Methods Research* Vol 1, Issue 1 pp 48-76, 2007

Morrell P (2009) A History of Homeopathy in Britain *Homeopathy4Everyone* May 2009 <http://www.hpathy.com/essentia/printpage.asp> [Accessed 1 June 2009]

Morrison R (1993) *Desktop Guide to Keynotes and Confirmatory Symptoms* California, Hahnemann Clinic Publishing

Morrison R (1998) *Desktop Companion to Physical Pathology* California, Hahnemann Clinic Publishing

Moskowitz (2004) The Fundamentalist Controversy: An Issue that Won't Go Away *The Homeopath* No 92 Winter 2004 The Society of Homeopaths

Moynihan R, Smith R (2005) *Too much medicine? Almost certainly* chapter 4 *Perspectives on Complementary and Alternative Medicine: A Reader* Editors: Lee-Treweek G, Heller T, Spurr S, MacQueen H, Katz J (2005) Abingdon Oxon, Routledge

Murray M (2008) *Doing Narrative Research* in Smith J (ed) *Qualitative Psychology* London, Sage

Neal M J (1997) *Medical Pharmacology at a Glance* UK, Blackwell Science Ltd

New England Centenarian Study (2008 - ongoing) <http://www.bumc.bu.edu/centenarian> [Accessed 2 June 2010]

NHS Evidence - complementary and alternative medicine (2010) *2010 Annual Evidence Update for Homeopathy – Results* <http://www.library.nhs.uk/cam/ViewResource.aspx?resID=377641> [Accessed 9 July 2010]

Nicholls P (2005) *Homeopathy, hospitals and high society* Chapter 22 *Perspectives on Complementary and Alternative Medicine: A Reader* Editors: Lee-Treweek G, Heller T, Spurr S, MacQueen H, Katz J (2005) Abingdon Oxon, Routledge

Norland M (2004) The Hermetic Tradition and Homeopathic Principles *The Homeopath* No 92 Winter 2004 The Society of Homeopaths

Northrup Christine (1998) *Women's Bodies, Women's Wisdom* New York, BCA

O'Dwyer S T, Burton N W, Pachana N A, Brown W J (2007) Protocol for Fit Bodies, Fine Minds: a randomized controlled trial on the affect of exercise and cognitive training on cognitive functioning in older adults *BMC Geriatrics* 2007, 7:23 doi:10.1186/1741-2318-7-23 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2094709/?tool=pmcentrez> [Accessed 10 July 2009]

Ong C K, Banks B (2004) *Complementary and Alternative Medicine: the consumer perspective: report of a pilot study into consumer use and preference for complementary and alternative medicine for the Prince of Wales's Foundation for Integrated Health* 2004 London, The Prince of Wales's Foundation for Integrated Health

Oschman J L (1997) *Energy medicine – the new paradigm* London, New Science and Traditional Concepts

Oschman J L (2000) *Energy Medicine: the scientific basis* Edinburgh, Churchill Livingstone

Owen D (2008) The need for super...vision *The Homeopath* Autumn 2008, 27:2 The Society of Homeopaths

Parliamentary return of the homoeopathic treatment of cholera *British Journal Homoeopathy* 1855; **13**: 674-88

Paterson C (1996) Measuring Outcomes in primary care: a patient generated means *BMJ* 1996;312:1016-1020 (20 April) <http://bmj.bmjjournals.com/cgi/content/full/312/7037/1016> [Accessed 13 October 2006]

Paterson C, Britten N (2000) In pursuit of patient-centred outcomes: a qualitative evaluation of MYMOP, Measure Yourself Medical Outcome Profile *Journal Health Service Res Policy* 2000;**5**:27-36

Paterson C (2006) Measuring changes in self-concept: a qualitative evaluation of outcome questionnaires in people having acupuncture for their chronic health problems. *BMC Complementary and Alternative Medicine* 2006;6 (7): doi:10.1186/1472-6882-6-7 <http://www.biomedcentral.com/1472-6882/6/7> [Accessed 1 July 2008]

Paterson C, Baats C, Launso L, Verhoef M (2009) Evaluating complex health interventions: a critical analysis of the 'outcomes' concept *BMC Complementary and Alternative Medicine* 2009, **9**:18 doi:10.1186/1472-6882-9-18 <http://www.biomedcentral.com/1472-6882/9/18> [Accessed 10 January 2010]

Piano Clark V L, Creswell J W (2008) *The Mixed Methods Reader* London, Sage Publications Ltd

Pilkington K, Kirkwood G, Rampes H, Fisher P, Richardson J (2005) Homeopathy for depression: A systematic review of the research evidence *Homeopathy*, 2005;94 (3) pp 153-163.

Pirmohamed M, James S, Meakin S, Green C, Scott A K, Walley T J, Farrar K, Park B K, Breckenbridge A M (2004) Adverse drug reactions as cause of admission to hospital: prospective analysis of 18,820 patients *BMJ* 2004;329:15-19 (3 July), doi:10.1136/bmj.329.7456.15 <http://www.bmj.com/cgi/content/abstract/329/7456/15> [Accessed 13 January 2009]

Pitari G (2006) Scientific research in homeopathic medicine: validation, methodology and perspectives *eCAM* 2006;4(2)271-273 doi:10.1093/ecam/ne1085 <http://ecam.oxfordjournals.org/cgi/content/full/4/2/271> [Accessed 6 December 2006]

Pittrof R, Rubenstein I (2008) The thinking doctor's guide to placebo *BMJ* 2008;336;1020 doi:10.1136/bmj.39564.454502.C2 <http://www.bmj.com/cgi/content/full/336/7651/1020?maxtoshow=&hits=10&RESULTFORMAT=1&author1=pittrof&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=date&volume=336&fdate=1/1/1998&resourcetype=HWCIT> [Accessed 2 May 2008]

Polgar S, Thomas S A (2000) *Introduction to Research in the Health Sciences* London, Churchill Livingstone

Pope C, Mays N (1995) Qualitative research: reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research *BMJ* 1995; **311**: 42-45

Prasad R (2007) Homeopathy booming in India *The Lancet* Vol 370 November 17, 2007

Quality Metric Incorporated (QM Inc 2009) *Generic Health Surveys* <http://www.qualitymetric.com/WhatWeDo/GenericHealthSurveys/tabid/184/Default.aspx> [Accessed 28 October 2009]

Quinn D (2008) Homeopathy and the integration of feelings *Hpathy Ezine* December 2008 <http://www.hpathy.com/papersnew/quinn/homeopathy-integration-feelings.asp> [Accessed 19 November 2008]

Rang H P, Dale M M, Ritter J M (1998) *Pharmacology* London, Churchill Livingstone

Reid, Flowers and Larkin (2005) *Interpretative Phenomenological Approach* London, Sage

Rees D G (2001) *Essential Statistics* London, Chapman and Hall

Reilly D T, Taylor M A, McSharry C, Atkinson T (1986) Is homeopathy a placebo response? Controlled trial of homeopathic potency, with pollen in hayfever as a model *Lancet* 29 November 1986 Vol 328 Issue 8518 page 1272  
[http://www.sciencedirect.com/science?\\_ob=ArticleURL&\\_udi=B6T1B-49MWTDR-3NC&\\_user=10&\\_coverDate=11%2F29%2F1986&\\_rdoc=20&\\_fmt=high&\\_orig=browse&\\_srch=docinfo\(%23toc%234886%231986%23996711481%23458564%23FLP%23display%23Volume\)&\\_cdi=4886&\\_sort=d&\\_docanchor=&view=c&\\_ct=57&\\_acct=C000050221&\\_version=1&\\_urlVersion=0&\\_userid=10&md5=39a2c710739e56713521eddfdaa1110](http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6T1B-49MWTDR-3NC&_user=10&_coverDate=11%2F29%2F1986&_rdoc=20&_fmt=high&_orig=browse&_srch=docinfo(%23toc%234886%231986%23996711481%23458564%23FLP%23display%23Volume)&_cdi=4886&_sort=d&_docanchor=&view=c&_ct=57&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=39a2c710739e56713521eddfdaa1110) [Accessed 1 June 2008]

Reilly D, Taylor M A, Beattie N G M, Campbell J H, McSharry C, Aitchison T C, Carter R, Stevenson R D (1994) Is the evidence for homeopathy reproducible? *The Lancet* 1994; **344**: 1601-06

Reilly D (2006) The fifth wave: inner life and emergent process in a post-reductionist age *The Society of Homeopath's conference* 25-27 March 2006, Oxford University

Richardson J (1996) Quasi-randomised control trial to assess the outcome of acupuncture, osteopathy and homoeopathy using the short form 36 item health survey *Health Services Research and Evaluation Unit* December 1996 The Lewisham Hospital NHS Trust

Richardson J (2005) Complementary and alternative medicine: socially constructed or evidence based? Chapter 3 *Perspectives on Complementary and Alternative Medicine: A Reader* Editors: Lee-Treweek G, Heller T, Spurr S, MacQueen H, Katz J (2005) Abingdon Oxon, Routledge

Richardson W R (2001) Patient benefit survey: Liverpool Regional Department of Homeopathic medicine *British Homeopathic Journal* **90** 158-162  
<http://www.ncbi.nlm.nih.gov/pubmed/11479784> [Accessed 17 July 2010]

Roberts A (2007) *Don't Die Young* London, Bloomsbury

Roberts R (2008) Integration of homeopathy into primary care *The National Health Executive (NHE) publication* December 2008 <http://www.homeopathy-soh.org/members/research/documents/Integratinghomeopathyintoprimarycare.doc> [Accessed 23 January 2009]

Ross S, Simpson C R, McLay J S (2006) Homeopathic and Herbal Prescribing in General Practice in Scotland *British Journal of Clinical Pharmacology* 2006;62:647-52

Rowntree D (2000) *Statistics without Tears* London, Penguin Books

Rubio E, Lazaro A, Sanchez-Sanchez A (2009) Social participation and independence in activities of daily living: a cross sectional study *BMC Geriatrics* 2009, 9:26doi:10.1186/1471-2318-9-26

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2713967/?tool=pmcentrez> [Accessed 18 November 2009]

Rutten A L B, Stolper C F (2008) The 2005 meta-analysis of homeopathy: the importance of post-publication data *Homeopathy* 2008 Volume 97, issue 4. October 2008, pages169-177

[http://www.sciencedirect.com/science?\\_ob=ArticleURL&\\_udi=B6WXX-4TPWK20-3&\\_user=152381&\\_rdoc=1&\\_fmt=&\\_orig=search&\\_sort=d&\\_view=c&\\_acct=C000012638&\\_version=1&\\_urlVersion=0&\\_userid=152381&md5=d0c35c4dafa603aa7199d3734d952c8](http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6WXX-4TPWK20-3&_user=152381&_rdoc=1&_fmt=&_orig=search&_sort=d&_view=c&_acct=C000012638&_version=1&_urlVersion=0&_userid=152381&md5=d0c35c4dafa603aa7199d3734d952c8) [Accessed 17 January 2009]

Samarasekera U (2007) Pressure grows against homeopathy in the UK *The Lancet* Vol 370 November 17 2007 [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)61708-5/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61708-5/fulltext) [Accessed 1 June 2008]

Saxton J (2006) President of the Faculty of Homeopaths Interview with Scotsman Newspaper 18 December 2006

Schiff M (1995) *The memory of water: homeopathy and the battle of ideas in the new science* (Translation of: *Un cas de censure dans la science: l'affaire de la memoire de l'eau*) London, Thorsons

Schmidt P (1921) *The Art of Case Taking* New Delhi, B Jain Publishers Ltd

Science and Technology Committee (2010) *Evidence Check 2: Homeopathy* HC 45, Fourth Report of Session 2009-10, Monday 22 February 2010 [www.parliament.uk/business/committees/committees-archive/science-technology](http://www.parliament.uk/business/committees/committees-archive/science-technology) [Accessed 16 June 2010]

Schmukler A V (2009) A New Paradigm for Potentization *Homeopathy 4 Everyone* February 2009 [www.hpathy.com/ezine.2009feb.asp](http://www.hpathy.com/ezine.2009feb.asp) [Accessed 16 February 2009]

Schofield J W (2007) *Increasing the generalizability of qualitative research* in Hammersley M (2007) editor of *Educational Research and Evidence-based Practice* The Open University Sage Publications Ltd

Scottish Neighbourhood Statistics (2009) *Change over time report for Scotland for the topic Population* <http://www.sns.gov.uk/default.aspx> [Accessed 19 December 2009]

Scottish Neighbourhood Statistics (2009) *Change over time report for Scotland for the topic Health* <http://www.sns.gov.uk/default.aspx> [Accessed 19 December 2009]

Scrutton S (1992) *Ageing, healthy and in control: an alternative approach to maintaining the health of older people* London, Chapman & Hall

Sevar, R (2000) Audit of outcome in 829 consecutive patients treated with homeopathic medicine *British Homeopathic Journal* Vol 89 No 4 October 2000

Shang A, Huwiler-Muntener K, Nartey L, Juni P, Dorig S, Sterne J A, Pewsner D, Egger M (2005) Are the clinical effects of homeopathy placebo effects? Comparative study of placebo-controlled trials of homeopathy and allopathy *Lancet* 2005, 366:726-732  
[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(05\)67177-2/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(05)67177-2/fulltext)  
[Accessed 1 June 2008]

Shealy C N, Thomlinson P R, Cox R H, and Bormeyer V (1998) Osteoarthritis Pain: A Comparison of Homoeopathy and Acetaminophen *American Journal of Pain Management*, 8, 3, July 1998, 89-91

Sherman R, Hickner J (2008) Academic Physicians Use Placebos in Clinical Practice and Believe in the Mind-Body Connection *Journal of General Internal Medicine*, Volume 23, Number 1, January 2008 DOI: 10.1007/s11606-007-0332-z  
[www.medicalnewstoday.com/articles/93003.php](http://www.medicalnewstoday.com/articles/93003.php) [Accessed 9 January 2008]

Sherwood L (1993) *Human Physiology From Cells to Systems* USA, West Publishing Company

Shmueli A, Shuval J (2006) Are users of complementary and alternative medicine sicker than non-users? *eCAM* 2006; 4(2) 251-255 doi:10.1093/ecam/ne1076  
<http://ecam.oxfordjournals.org/cgi/content/full/4/2/251> [Accessed 31 October 2006]

Siddell M (1995) *Health in Old Age myth, mystery and management* Milton Keynes, Open University Press

Simpson S H, Eurick D T, Majumdar S R, Padwal R S, Tsuyuki R T, Varney J, Johnson J A (2006) A meta-analysis of the association between adherence to drug therapy and mortality *BMJ* 2006;333:15 doi:10.1136/bmj.38875.675486.55)  
<http://bmjcom.highwire.org/cgi/content/full/333/7557/15> [Accessed 20 February 2010]

Singh N (2008) The 'Sweet' Pill *Express Healthcare* November 2008  
<http://www.expresshealthcaremgmt.com/200811/market01.shtml> [Accessed 1 December 2008]

Sirious F S, Gick M L (2002) An investigation of the health beliefs and motivations of complementary medicine clients *Social Science and Medicine* Vol 55 pp 1025-3

Smith J (2009) Practitioner Experience *The Homeopath* Summer 2009, 28:1 The Society of Homeopaths

Society of Homeopaths (2006) *National Service Evaluation Phase 1: an uncontrolled prospective study* <http://www.homeopathy-soh.org/for-members/research/> [Accessed 27 January 2009]

Society of Homeopaths (2007) Re: commissioning of homeopathic services in the NHS *Press release* 23 May 2007

Society of Homeopaths (2007) Letter to the editor of The Lancet from Paula Ross 16 November 2007

Society of Homeopaths (2010) *Code of Ethics and Practice April 2010* Northampton, Society of Homeopaths

Society of Homeopaths ([mail\\_me@homeopathy-soh.org](mailto:mail_me@homeopathy-soh.org)) 2010 *Support for homeopathy on the NHS* 29 June 2010 e-mail to Jan Schyma and members of the Society of Homeopaths ([jan@schyma.co.uk](mailto:jan@schyma.co.uk))

Society of Homeopaths (2010) Evidence base for homeopathy <http://www.homeopathy-soh.org/whats-new/research/evid/default.aspx> [Accessed 17 July 2010]

Souter K (1993) *Homeopathy for the Third Age* Saffron Walden, The C W Daniel Company Limited

Spence D S, Thompson E (2005) Homeopathic Treatment for Chronic Disease: A 6 Year University Hospital Outpatient Observational Study. *The Journal of Alternative and Complementary Medicine* Volume 11, Number 5, 2005, pp 793-798

Spiegel D, Harrington A (2008) What is placebo worth? *BMJ* 2008;336:967-968 doi:10.1136/bmj.39535.344201.BE  
<http://www.bmj.com/cgi/content/full/336/7651/967?maxtoshow=&hits=10&RESULTFORMAT=1&author1=harrington&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=date&volume=336&fdate=1/1/1981&resourcetype=HWCIT> [Accessed 2 May 2008]

Sternberg E M (2000) *The Balance Within: the science connecting health and emotions* New York, W H Freeman and Company

Sternberg S (2009) Clinicians becoming active in research *The Homeopath* Summer 2009, 28:1 The Society of Homeopaths

Stone J (1996) *Complementary Medicine and the Law* Oxford University Press

Swayne J (1992) The cost effectiveness of homoeopathy A pilot study, proposals for future research. *British Homoeopath Journal* 1992; 81: 148–150



Sullivan C (2003) *Polypharmacy: what cost in morbidity and mortality?* New England Forensic Sciences Conference at Colby College

Taylor M A, Reilly D, Llewellyn-Jones H, Aitchison T C (2000) Randomised controlled trial of homeopathy versus placebo in perennial allergic rhinitis with overview of four trial series *BMJ* 2000; 321: 471-476

Teut M, Ludtke R, Schnabel K, Willich S N, Witt C M (2010) Homeopathic treatment of elderly patients – a prospective observational study with follow up over a two year period *BMC Geriatrics* 2010, 10:10 doi: 10.1186/1471-2318-10-10  
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2841176/> [Accessed 24 February 2010]

Thompson E A (1999) Using homeopathy to offer supportive cancer care, in a National Health Service outpatient setting *Complementary Therapies in Nursing & Midwifery* 1999, 5, 37- 41

Thompson E A (2004) A preliminary audit investigating remedy reactions including AE's in routine homeopathic practice *Homeopathy* 93:203-209

Thompson E A, Thompson T D B (2006) Placebo or non-specific effects: what are the unique ingredients in homeopathy? *The Homeopath* Winter 2006, 25:3 The Society of Homeopaths

Thompson E A, Relton C (2009) Designing clinical trials of homeopathy for menopausal symptoms: a review of the literature *Menopause International* 2009, 15: 31-34  
<http://mi.rsmjournals.com/cgi/content/abstract/15/1/31> [Accessed 2 June 2010]

Thompson T, Weiss M, (2006) Homeopathy – what are the active ingredients? An exploratory study using the UK Medical Research Councils framework for the evaluation of complex interventions *BMC Complementary and Alternative Medicine* 2006, 6:37  
<http://www.biomedcentral.com/1472-6882/6/37> [accessed 3 January 2007]

Thomson W G (2005) *The Placebo Effect and Health* New York, Prometheus Books

Townsend I (2004) *Almost nothing to do: supervision and the person-centred approach in homeopathy* in Tudor K, Worrall M (2004) editors of *Freedom to Practise: Person-centred approaches to supervision* (pp 225 – 245) Ross-on-Wye, PCCS Books

Treacher S (1996) *Practical Homeopathy* Bristol, Parragon Book Service Ltd

Trichard M, Chaufferin G, Nicolayannis N (2005) Pharmaco-economic comparison between homeopathic and antibiotic treatment strategies in recurrent rhinopharyngitis in children *Homeopathy* 2005, 94:3-9

Tyler M L (reprint 1995) *Homeopathic Drug Pictures* India, B Jain Publishers Ltd



- UK National Statistics (2009) *Publication Hub Older People* <http://www.statistics.gov.uk/hub/population/ageing/older-people/index.html> [Accessed 19 December 2009]
- Ullmann D (2010) Homeopathic Medicine is Nanopharmacology *Institute of Science in Society website* <http://www.i-sis.org.uk/nanopharmacology.php> [Accessed 1 August 2010]
- Van Wassenhoven M (2005) Priorities and methods for developing the evidence profile of homeopathy: Recommendations of the ECH General Assembly and XVIII Symposium of GIRI *Homeopathy*, 2005: 94 (2), pp 107-124.
- Van Wassenhoven M (2008) Scientific framework of homeopathy: evidenced-based homeopathy *International Journal of High Dilution Research* volume 7, issue 23, p 28050 June 2008
- Van Wassenhoven M (2008) *First Line Medicine: Clinical Verification* Assesse Belgium, B Jain Publishers Ltd
- Verhoef M J, Casebeer A I, Hilsden R J (2005) *Assessing efficacy of complementary medicine: adding qualitative research methods to the 'gold standard'* Ed: Lee-Treweek G, Heller T, Spurr S, MacQueen H, Katz J (2005) *Perspectives on Complementary and Alternative Medicine: A Reader* Abingdon Oxon, Routledge
- Verhoef M, Vanderheyden L, Dryden T, Mallory D, Ware M (2006) Evaluating complementary and alternative medicine interventions: in search of appropriate patient centered outcome measures *BMC Complementary and Alternative Medicine* 2006 6:36 <http://www.biomedcentral.com/1472-6882/6/38> [Accessed 21 November 2006]
- Vermeulen F (1997) *Concordant Materia Medica* The Netherlands, Emryss Publishers
- Vincent C, Furnham A (1997) *Complementary Medicine: A Research Perspective* Chichester, Wiley & Sons
- Vithoulkas George (1979) *Homeopathy Medicine of the New Man* London, Thorsons
- Vithoulkas G (1980) *The Science of Homeopathy* New Delhi, B Jain Publishers Ltd
- Walach H, Falkenberg T, Fønnebø V, Lewith G, Jonas W B (2006) Circular instead of hierarchical methodological principles for the evaluation of complex interventions *BMC Medical Research Methodology* Volume 6, 2006, Page 29 <http://www.biomedcentral.com/1471-2288/6/29> [Accessed 21 November 2006]

Wapf V, Busato A (2007) Patients motives for choosing a physician: a comparison between conventional and complementary medicine in Swiss primary care *BMC Complementary and Alternative Medicine* 2007, 7:38 doi:10.1186/1472-6882-7-38 <http://www.biomedcentral.com/1472-6882/7/41> [Accessed 1 June 2008]

Ware J E (1993) Measuring patients' views: the optimum outcome measure *BMJ* 1993 May 29; 306(6890): 1429–1430  
<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1677908> [Accessed 8 January 2009]

Ware J E (1993) *SF-36 Health Survey: Manual and Interpretation Guide* The Health Institute, New England Medical Center

Ware Jr J E, Gandek B (1999) *Overview of the SF-36 Health Survey and the International Quality of Life Assessment (IQOLA) Project*  
[http://www.sciencedirect.com/science?\\_ob=ArticleURL&\\_udi=B6T84-3W4GR1T-3&\\_user=10&\\_rdoc=1&\\_fmt=&\\_orig=search&\\_sort=d&\\_docanchor=&view=c&\\_searchStrId=1003238306&\\_rerunOrigin=scholar.google&\\_acct=C000050221&\\_version=1&\\_urlVersion=0&\\_userid=10&md5=3f3fce1a6e0c0e2a6519f2c7770ead5e](http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6T84-3W4GR1T-3&_user=10&_rdoc=1&_fmt=&_orig=search&_sort=d&_docanchor=&view=c&_searchStrId=1003238306&_rerunOrigin=scholar.google&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=3f3fce1a6e0c0e2a6519f2c7770ead5e)  
[Accessed 8 January 2009]

Ware J E (2000) SF-36 Health Survey Update *Spine*: 15 December 2000 - Volume 25 - Issue 24 - pp 3130-3139 Focus Issue

Ware J E, Dewey J E, Kosinski M (2002) *How to score version 2 of the SF-36 health survey (standard & acute forms)* Lincoln, QualityMetric Inc

Weatherley-Jones E, Relton C (2003) Researching Homeopathic Treatment – can the placebo model really be an appropriate test of homeopathy? *The Homeopath* (2003) 88, 24-25 The Society of Homeopaths

Weatherley-Jones E, Thompson E A, Thomas K J (2005) The Placebo-controlled trial as a test of complementary and alternative medicine: observations from research experiences of individualized homeopathic treatment *Homeopathy* (2004) 93, 186-189 The Faculty of Homeopathy

Weil A (1996) *Spontaneous Healing* USA, Warner Books

Weil A (1998) *8 Weeks to Optimum Health* UK, Little Brown and Company

Wensing M, Jung H P, Mainz J, Olesen F, Grol R (1998) A systematic review of the literature on patient priorities for general practice care *Social Science and Medicine* 47(10): 1573-1588 Nov 1998

Why homeopathy is such a bargain <http://www.ntskeptics.org/cartoons/weekly.htm>  
[Accessed 9 February 2009]

Willig Carla (2001) *Introducing Qualitative Research in Psychology* Maidenhead, Open University Press

Willig Carla (2001) *Qualitative Research in Psychology - Adventures in Theory and Method* Maidenhead, Open University Press

Wilmot A (2005) *Designing sampling strategies for qualitative social research*  
Government statistics website  
[http://www.statistics.gov.uk/about/services/dcm/downloads/AW\\_Sampling.pdf](http://www.statistics.gov.uk/about/services/dcm/downloads/AW_Sampling.pdf)  
[Accessed 31.12.10]

Winterson J (2007) In defence of homeopathy *Guardian* newspaper 13 November 2007  
[www.guardian.co.uk/g2/story/0,2209998,00.html](http://www.guardian.co.uk/g2/story/0,2209998,00.html) [Accessed on 13 November 2007]

Witt C, Keil T, Selim D, Roll S, Vance W, Wegscheider K, Willich S N (2005) Outcome and costs of homeopathic and conventional treatment strategies: A comparative cohort study in patients with chronic disorders *Complementary Therapies Medicine* 2005, 13: 79-86

Witt C, Ludtke R, Mengler N, Willich S N (2008) How healthy are chronically ill patients after eight years of homeopathic treatment? Results from a long term observational study *BMC Public Health* 2008, 8;413 doi:10.1186/1471-2458-8-413  
<http://www.biomedcentral.com/1471-2458/8/413> [Accessed 20 December 2008]

World Health Organization (WHO) (1998) *WHOQOL and Spirituality, Religiousness and Personal Beliefs: Report on WHO Consultation* Geneva, WHO

Wright C (2008) *Fire and metabolism – the thyroid gland and the endocrine system* the Society of Homeopaths continuing professional development programme, Quaker Meeting House, Edinburgh 27 September 2008

Wright N, Smeeth L, Heath I (2003) Moving beyond single and dual diagnosis in general practice *British Medical Journal* 2003;326:512-514

Yank V, Rennie D, Bero L A (2007) Financial ties and concordance between results and conclusions in meta-analyses: retrospective cohort study *BMJ* 2007 doi: 10.1136/bmj.39376.447211.BE  
<http://www.bmj.com/cgi/content/full/335/7631/1202?maxtoshow=&hits=10&RESULTFORMAT=1&author1=yank&author2=rennie&title=financial+ties&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=date&fdate=1/1/1981&resourcetype=HWCIT> [Accessed 10 July 2008]

Yardley L, Smith J A (Ed) (2008) *Qualitative Psychology A Practical Guide to Research Methods* London, Sage Publications Ltd



## APPENDICES

- Appendix 1: Proving homeopathic remedies
- Appendix 2: Analysing symptoms using computer software
- Appendix 3: Extract from Materia Medica
- Appendix 4: Participant interview questions
- Appendix 5: Ethical approval for study
- Appendix 6: Information about homeopathy for participants
- Appendix 7: Participant consent form
- Appendix 8: Introduction to homeopathic consultation
- Appendix 9: Illustration of analysis of interview questions
- Appendix 10: Dates of appointments attended by participants
- Appendix 11: Remedies prescribed to participants
- Appendix 12: Common themes and participant experiences
- Appendix 13: Unexpected outcomes of homeopathic treatment
- Appendix 14: Measure Your Own Medical Profile (MYMOP)
- Appendix 15: SF-36 questionnaire
- Appendix 16: An overview of positive homeopathy research
- Appendix 17: Examples of Crosstabulation and Chi-Square tests for SF-36 data



## Appendix 1: Proving homeopathic remedies

The methods used for proving homeopathic remedies were specified by Samuel Hahnemann (1755 – 1843) the founder of homeopathy. The proving is carried out by groups of 10 – 15 volunteers, led by a master prover. The master prover also has a committee of two others to help him and the services of supervisors. The remedy is chosen and produced in its purest form by a qualified pharmacist. The remedy is coded so that proving is blind. (The raw extract of the substance chosen is made into a tincture with alcohol which forms the basis of the dilution procedure. Dilutions are made up to either 1 part tincture to 10 parts water (1x) or 1 part tincture to 100 parts water (1c). Repeated dilution results in the 6x, 6c or 30c potencies that can be bought over the counter. The 30c contains less than 1 part per million of the original substance.)

The provers have to be healthy and avoid stress and pollutants for a month before the proving. The supervisors take the case history before the provers take the remedy to be tested. Each prover keeps a diary of physical, mental and emotional symptoms for two weeks before taking the remedy and for an agreed amount of time afterwards. The prover takes six doses of the remedy a day for two days. The prover stops taking the remedy when symptoms develop or if nothing happens. All changes are noted in the prover's diary and discussed daily with the supervisor. The proving is usually concluded after four weeks, but checks are carried out after six months and a year. According to Coulter (1980) provers today would show the same symptoms as the provers of the past when exposed to the same remedies.

The master prover collates all the information and produces graded symptoms that occurred in different numbers of provers. The highest grade is given to the symptoms that most provers report experiencing, or that noticeable numbers of provers experience very strongly. All the records are kept and used for future reference by prescribers of homeopathic remedies. These records are available in *Materia Medica* and *Homeopathic Repertories*. In printed versions of the repertories the remedies are graded using heavy black type for symptoms that were frequently experienced by provers taking a particular



remedy, italics for symptoms that were often experienced when taking a particular remedy and plain type for symptoms that are sometimes experienced when taking a particular remedy. Symptoms that are listed are believed to be resolved by taking the remedy that produced the symptoms during the proving. Computer systems for homeopathic repertorising use a numbering system, with 3 representing bold type, 2 representing italics and 1 representing plain typeface. An example of computerised repertorisation is given in Appendix 2.

## Appendix 2: Analysing symptoms using computer software

		Lach	Puls	Bry	Bell	Carb-v	Phos	Sep	Sulph	Tub	Calc	Glon	Ign
		13	14	10	10	7	9	10	11	9	5	7	6
		7	7	6	5	5	5	5	5	5	4	4	4
		13	14	10	10	7	9	10	11	9	5	7	6
MENOPAUSE,	M Female	3	3	2	2	1	2	3	3		1	2	2
MENOPAUSE, hot flashes, with, perspiration	M Female	2	2		1	2	1	3	2	3			
MILK, aversion to	M Food	1	2	2	1	2	2	2	2	1	2		2
HEATED, becoming agg. sun, or fire, agg.	M Enviroment	1	1	2	3	1						3	
COLD, temperature, cold, amel. windows open, must h	M Enviroment	2	2	1		1			2	1	1	1	
CHANGE, desire for,	M Mind			2				1		3			1
SOCIABLE	M Mind	1	2				2						
RAGE,	M Mind	3	2	1	3		2	1	2	1	1	1	1

## Appendix 3: Extract from Materia Medica

### **Rhus Toxicodendron**

Modalities: The complaints of this remedy come on from cold damp weather, from being exposed to cold damp air when perspiring.

The patient is sensitive to cold air and all his complaints are made worse from cold and all are better from warmth. In a general way, the aching pains, the bruised feelings over the body, restlessness throughout the limbs, and amelioration from motion are features that prevail throughout all conditions of Rhus.

While he is better from motion and better from walking, if he continues to walk he becomes exhausted. Any continued exertion of the body or mind exhausts the Rhus patient. He suffers from rheumatic conditions with pains in the bones, lameness in the muscles, lameness in the tendons, ligaments, and joints from suppression of sweat, from becoming chilled.

These occur with or without fever. Rhus is suitable in old chronic rheumatic conditions. He is stiff, lame, and bruised on first beginning to move. This passes off on becoming warm, but soon he becomes weak and must rest.

Kent James Tyler (1900) *Lectures on Homeopathic Philosophy* India, B Jain Publishers Ltd

## **Appendix 4: Participant interview questions**

AN INVESTIGATION INTO THE EFFECTIVENESS OF HOMEOPATHY IN  
IMPROVING PERCEIVED WELL BEING AND QUALITY OF LIFE IN THE 55+  
AGE GROUP

CARRIED OUT BY HOMEOPATH/RESEARCHER JAN SCHYMA

The following questions are designed to help you discuss the experience you have had of homeopathic treatment as part of a research project. Your answers will be recorded on tape and then transcribed. All your responses are confidential and will be used in the research project in the way described in the research information sheet. Thank you for answering these questions and for taking part in the research project.

### **Research questions**

Additional information is provided at the end to define some terms and provide more detail for some questions.

1. What was your view of homeopathy before starting treatment?
2. How would you describe your experience of homeopathy to someone who knew nothing about it?
3. Tell me about your experience of the homeopathic consultations. (See note)
4. Tell me about your experience of the effects of taking the homeopathic remedies.
5. Tell me about your experience of discussing self care in the consultations and the effect on your behaviour between consultations. (See note)

6. Do you think your beliefs about homeopathy, or your beliefs about health, or the placebo effect, made any difference to the outcome of the treatment? Give some reasons for your answer if you can. (See note)

7. Do you think the therapeutic relationship with the homeopath made any difference to the outcome of the treatment? Give some reasons for your answer if you can. (See note)

8. Do you think contact with the homeopath between appointments, by e-mail, phone or letter made any difference to the outcome of the treatment? Give some reasons for your answer if you can.

9. Do you believe that you accurately described your symptoms and changes that you experienced during treatment? Give some reasons for your answer if you can.

10. Were your responses in the homeopathic consultation affected by your view of the homeopath or her questions or comments? Give some reasons for your answer if you can. (See note)

11. Which of the following made the most difference to your health: the remedy, interaction with the homeopath, self care or any other factor? Give some reasons for your answer if you can.

12. This is a research project and consultations were free of charge. Did this make any difference to your view of the treatment process? Give some reasons for your answer if you can.

13. The consultations were carried out in a home office. Did this make any difference to your view of the treatment process? Give some reasons for your answer if you can.

14. Is there anything that you would change about your experience of homeopathic treatment?

15. Any other comments?

### **Additional information to define terms or explain interview questions**

**Question 3:** Tell me about your experience of the homeopathic consultations.

How did you feel at first? Did that feeling change? Were there any positive or negative aspects? Did you think about the consultations afterwards or discuss what was said with anyone else?

**Question 5:** Tell me about your experience of discussing self care in the consultations and the effect on your behaviour between consultations.

We may have talked about diet, exercise, relaxation, work/life balance etc. Did it make you think about the way you live or change behaviour which affects your health?

**Question 6:** Do you think the placebo effect or your beliefs about the treatment made any difference to the outcome of the treatment?

The placebo effect is a term used to describe the health benefits gained from treatment that has no active ingredient. In medical research, participants are often divided into two groups. One group receives active treatment eg a drug, and the other group is given a dummy treatment eg a sugar pill. Participants don't usually know which treatment they've received, but some participants in the group receiving the placebo are likely to experience an improvement in symptoms.


**Question 7:** Do you think the therapeutic relationship with the homeopath made any difference to the outcome of the treatment?

The therapeutic relationship is a term used to describe the health benefits gained from interaction with someone you trust or have a rapport with. The healing effect of a therapeutic relationship may alleviate symptoms, provide encouragement and help individuals to believe they can improve their health.

**Question 10:** Were your responses in the homeopathic consultation affected by your view of the homeopath or her questions or comments?

Comments by the therapist, her non-verbal communication, her use of examples or the way questions are phrased may have an impact on the way patients respond. It has also been suggested that patients give answers that they think are expected of them or they try to please the therapist by giving positive feedback. Patients may also wish to present themselves in a particular way to the therapist.

## Appendix 5: Ethical approval for study



Queen Margaret University College  
EDINBURGH

Jan Schyma  
24 Ormildale Terrace  
Edinburgh  
EH12 6EQ

Dawn Martin  
Assistant Registrar (Quality Enhancement)  
Queen Margaret University College  
Clerwood Terrace  
Edinburgh EH12 8TS  
**Direct Dial**  
Tel 0131 317 3211 Fax 0131 317 3248  
Email: dmartin1@qmul.ac.uk

31 July 2006

Dear Jan

**Request for Ethical Approval for a Research Project: An investigation of the role of homeopathy in perceived well being and quality of life in the 55+ age group**

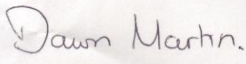
Thank you for resubmitting your application for ethical approval to the Research Ethics Committee.

Alanah Kirby, Convener of the Committee, has reviewed your response to the points you were required to address, and has confirmed that she is happy to take Convener's Action to grant full ethical approval for your research.

A standard condition of this ethical approval is that you are required to notify the Committee, in advance, of any significant proposed deviation from the original protocol. Reports to the Committee are also required once the research is underway if there are any unexpected results or events that raise questions about the safety of the research. Notification of completion of the study is also required – please find the appropriate form for this enclosed.


We would like to thank you for your co-operation and wish you well with your project.

Yours sincerely,



Dawn Martin  
Secretary to the Research Ethics Committee

Cc: Dr Mary Warnock, Director of Studies



THE QUEEN'S  
ANNIVERSARY PRIZES  
2002

Campuses at Corstorphine, Edinburgh EH12 8TS | Leith, Edinburgh EH6 8HF | Gateway Theatre, Edinburgh EH7 4AH  
Telephone +44(0)131 317 3000 www.qmul.ac.uk  
Company limited by guarantee. Registered in Scotland - N°7335 Scottish Charity - N°SC2750

ESTABLISHED 1875 125 YEARS OF EXCELLENCE



## **Appendix 6: Information about homeopathy for participants**



Queen Margaret University  
EDINBURGH

### **Information Sheet for Potential Participants in Homeopathy Research Project**

My name is Jan Schyma and I am a registered homeopath and a research student at Queen Margaret University in Edinburgh. I am looking for volunteers who would be willing to take part in my research.

The title of my research project is:

**An investigation into the effectiveness of homeopathy in improving perceived well being and quality of life in the 55+ age group**

The aims of this study are:

- ◇ To determine whether homeopathy is effective in improving health, well being and quality of life in the 55+ age group
- ◇ To explore common themes in the homeopathic treatment process for the 55+ age group

Homeopathy is a form of complementary medicine which treats the whole person using natural remedies. The World Health Organisation (2004) estimates that homeopathy is the second most popular complementary therapy in the world, practised in about 67 countries with 300 million users. Homeopathy is described by the Society of Homeopaths as a therapy that is safe, non-toxic, has no side effects and can be used to treat most health problems at all stages of life.

Would you be willing to be a volunteer and participate in this study?

**The criteria for taking part are that you are:**

- aged 55 or over
- able to identify health problems that affect your quality of life
- willing to attend four appointments with me over a six month period and discuss your health and health related issues
- willing to complete questionnaires and give verbal feedback about your experience of homeopathic treatment

If you agree to participate in the study, you will be asked to attend a homeopathic consultation lasting about two hours and three follow up appointments lasting about an hour each, over a six month period. These appointments will take place at my clinic, based in my home at 24 Ormidale Terrace, Murrayfield, Edinburgh EH12 6EQ.

If you would like more information or to make arrangements to take part, please contact me by phone on 0131 337 3028 or e-mail [jan@schyma.co.uk](mailto:jan@schyma.co.uk) or text 0772 070 5271. If you would like to know more about my practice and homeopathy, I can send you a leaflet or you can visit my website at [www.homeopathyedinburgh.co.uk](http://www.homeopathyedinburgh.co.uk). To confirm my qualifications and ethical code of practice, contact the Society of Homeopaths on 0845 450 6611 or visit their website at [www.homeopathy-soh.org](http://www.homeopathy-soh.org).

**Reasons why you might not be able to take part in the research:**

If you have had major surgery, chemotherapy or radiotherapy or other significant medical treatment in the last year, or you develop a major illness during the study, it will not be possible to take part in this research. (In the event of a new illness occurring during the trials, participants should seek medical advice and inform the doctor of the nature of the homeopathic treatment they have received.)

You will be free to withdraw from the study at any stage and you would not have to give a reason. All the information that you give will be confidential. It will not be possible for you to be identified in any reporting of the data gathered. The results may be published in a journal or presented at a conference.

If you would like to contact an independent person, who knows about this project but is not involved in it, you are welcome to contact Dr Douglas McBean. His contact details are given below.

**Name of adviser:** Dr Douglas McBean

Faculty of Health and Social Sciences  
School of Dietetics, Nutrition and Biological Sciences  
Queen Margaret University, Edinburgh  
Queen Margaret University Drive  
Musselburgh  
East Lothian, EH21 6UU

E-mail / telephone: dmcbean@qmuc.ac.uk / 0131 474 0000

**Name of researcher:** Jan Schyma

Address: Research Student,  
Faculty of Health and Social Sciences  
School of Dietetics, Nutrition and Biological Sciences  
Queen Margaret University, Edinburgh  
Queen Margaret University Drive  
Musselburgh  
East Lothian, EH21 6UU

## Appendix 7: Participant consent form



Queen Margaret University

EDINBURGH

Consent Form

**“An investigation into the effectiveness of homeopathy in improving perceived well being and quality of life in the 55+ age group”**

I have read and understood the information sheet and this consent form. I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in this study.

I understand that I have the right to withdraw from this study at any stage without giving any reason.

I agree to participate in this study.

Name of participant: \_\_\_\_\_

Signature of participant: \_\_\_\_\_

Signature of researcher: \_\_\_\_\_

Date: \_\_\_\_\_

Name of researcher: Jan Schyma

Contact details of the researcher:

Faculty of Health and Social Sciences  
School of Dietetics, Nutrition and Biological Sciences  
Queen Margaret University, Edinburgh  
Queen Margaret University Drive  
Musselburgh  
East Lothian EH21 6UU

E-mail / telephone: [Jschyma@QMUC.ac.uk](mailto:Jschyma@QMUC.ac.uk) / 0131 474 0000

## **Appendix 8: Introduction to homeopathic consultations**

### **Introduction to first consultation**

After the participant has filled in the research questionnaires and the practice form giving contact details and information about past health issues, drugs and vaccinations, a light comment was made, such as, “That’s the most difficult part of the process,” then the following explanation of the consultation process was provided.

“I’ll just tell you a bit about my research, then explain the aim of the homeopathic consultation and the different areas we’ll cover. The research is looking at homeopathy as a complex intervention. There are three parts to this: the remedy which I’ll tell you more about in a moment; the experience of telling your story and perhaps seeing connections or becoming aware that you always behave in a certain way, or simply being listened to can be a positive experience; thirdly, the discussion of self care – I try not to give advice, but we may discuss something which you think might help you and we’ll see if that discussion makes a difference to your self care.

I’ll just tell you a bit about homeopathy first of all. Homeopathy was discovered by a man called Hahnemann about 200 years ago. He was translating a medical text book and disagreed with something it said about quinine. He took some quinine himself and developed the symptoms of malaria. From this came his theory that like cures like – or a natural substance which produces symptoms in someone who is well, will cure those same symptoms in someone who is ill. The most important thing is to find the right remedy for you as an individual and so we have to find out how you’re experiencing being unwell in order to match it up with the symptoms described by the people who proved the remedies. It’s important to know what being unwell is like for you, so many people say that they feel tired, but I need to know if they fall asleep after lunch, or if they’re letting tasks pile up or they look at a flight of stairs and feel too tired to climb them. I also need to know things that you might say are not worth mentioning. Someone

once said it probably wasn't worth mentioning but the top of his mouth was itchy and when I came to choose between two remedies that was helpful information. It's good if you can tell me about the experiences you've had which have been important to you, but it's most important to tell me how you felt. It's common for two people to experience the same thing but for one to feel very angry and the other to be sad or disappointed. It's also important to know how you are when you're not okay – this may not be a very flattering picture but it shows what you're like when you're out of balance. My own experience of this last Christmas is a good example. One daughter moved home, another one was having a baby and we looked after her toddler, my mum was ill and we had 20 people for Christmas dinner. By the end of the holiday I felt very fed up, resentful, I was snapping at my husband and my joints ached in bed at night. This isn't a pretty picture but it's not the way I am normally, this was me when things were out of balance.

The consultation has five parts but we can deal with them in any order. You keep telling me all you can and I'll type what you say, and then I'll ask questions if you run out of steam. We'll begin by looking at the symptoms you hope homeopathy can help with. Then we'll go over your health history and a little bit about family health trends. Then we'll consider lifestyle but not so much what you do to keep yourself well as what the body is telling us about your health. So if you tell me that you eat 20 bars of chocolate a day, I don't think about this in terms of weight gain but more that the body is craving chocolate. Then we look at personality and as I said before it's the way you are when you're under pressure that is important. Finally we'll do a tour round the body from head to toe and try and pick up any smaller symptoms not mentioned earlier.

After this I'll read you some remedy pictures so that you can tell me a bit more about the way you are when you're not okay. Many of the remedies are helpful for common physical symptoms but it's much more difficult to know your personality and reading the remedy pictures lets you tell me how you fit with particular remedies. After the consultation I put the main symptoms you've described into a computer programme and it highlights and scores all the remedies which might be suitable. When I've chosen a

remedy, I'll post it to you with instructions on how to take it. It'll be a small dropper bottle and you take one drop a day. If we've got the right remedy you'll notice something happening within two to three weeks, not necessarily the main symptom changing but something will happen. If nothing happens please let me know and we'll consider changing to another well indicated remedy.

Before we start the consultation it can be quite helpful for you to ask any questions so that you're not thinking throughout 'I must remember to ask that'."

### **Introduction to follow up consultation**

"What we need to do today is consider what's happened since last we met. The question we need to answer is 'how are you?' so if you can tell me as much as you can about how you've felt since you started taking the remedy and then I can ask some questions to fill in any gaps. When we've finished, there are three possibilities: to wait and see how things progress, to change the remedy, or continue with the same remedy, perhaps at a different level. Is there anything you want to ask before we begin?"

"That does happen when you've taken a remedy..."

"Patients commonly report similar experiences after taking a remedy..."

"People say things like 'I cleared out my kitchen cupboards and I've been meaning to do that for ages.'"

## Appendix 9: Illustration of analysis of interview questions

**Interview question 1:** What was your view of homeopathy before starting treatment?

P	Attitude to homeopathy	Experience of success with homeopathy
	"I hadn't really thought an awful lot about it to be honest"	Sister
	"I didn't know anything about it"	"so many people subscribe to it"
	"I'm a great believer in it"	Used as a teenager and for own children
	"I think I had an open mind about it"	"I had been to a homeopath when I had an allergy one time and I also had experience because my daughter used it"
	"it depends on the openness to hearing what I've got to say"	"My experience of homeopathy was that it was very effective before."
	"Open minded and maybe a kind of wait and see attitude"	"I didn't really know anything about it at all"
	"I didn't know much about it"	"I've had friends who've said, 'I've tried homeopathic remedies' but not through a homeopath"
	"I hadn't really thought about it before"	"I looked it up on the internet and found it quite interesting"
	"I came to it feeling very positive."	"I'd encountered it a long time ago"
	"I was open-minded about it"	
	"I'm quite a believer in it"	"I'd had homeopathy before"
	"what I knew about it was positive"	"I've used some standard remedies in the past"
	"fairly open minded"	"having years ago visited a homeopath, can't quite remember why I did ... I've met a lot of people who swear by it"
	"I certainly didn't have an educated view" "not actually sure if I know what it is now"	
	"I've always, always been interested in it and always believed in it if that makes any sense"	"I've known about homeopathy for years and years"
	"I didn't have much information about it."	
	"only knew a little about it"	
	"positive"	"I had some experience of it."
	"positive"	Daughter
	"I actually hadn't given it much thought"	



## Appendix 10: Dates of appointments attended by participants

<b>P</b>	<b>A1</b>	<b>A2</b>	<b>A3</b>	<b>A4</b>
	14.01.07	15.02.07	24.03.07	03.08.07
	03.11.07	08.12.07	12.01.08	16.02.08
	21.01.08	05.03.08	02.04.08	01.05.08
	23.01.08	03.03.08	03.04.08	02.05.08
	30.01.08	29.02.08	28.03.08	01.05.08
	09.02.08	15.03.08	10.05.08	14.06.08
	12.02.08	10.03.08	15.04.08	27.05.08
	23.02.08	22.03.08	05.05.08	26.05.08
	26.02.08	20.03.08	22.04.08	15.05.08
	29.02.08	02.04.08	08.05.08	12.06.08
	01.03.08	29.03.08	26.04.08	24.05.08
	05.03.08	11.04.08	16.05.08	17.06.08
	11.03.08	11.04.08	07.05.08	28.05.08
	13.03.08	04.04.08	02.05.08	30.05.08
	17.03.08	16.04.08	14.05.08	11.06.08
	22.03.08	16.04.08	14.05.08	11.06.08
	26.03.08	29.04.08	20.05.08	16.07.08
	18.04.08	23.05.08	20.06.08	09.07.08
	23.04.08	12.06.08	09.07.08	01.08.08
	30.05.08	27.06.08	23.07.08	12.08.08

## Appendix 11: Remedies prescribed to participants

P	Prescription 1	Prescription 2	Prescription 3	Prescription 4	Prescription 5	Acute prescriptions
	Phos LM1	Phos LM2	Ars alb LM1	Ars alb LM2	Ars alb LM3	
	No remedy	No remedy	No remedy	No remedy		
	Nat mur LM1	Nat mur LM2	Nat mur LM2	Nat mur LM2	Nat mur LM3	Hepar Sulph 30
	Nux vom LM1	Nux vom LM2	Nux vom LM2	Nux vom LM2		
	Calc carb LM1	Calc carb LM1	Pulsatilla LM1	Pulsatilla LM1		Hepar Sulph 30
	Nat mur LM 1	Nat mur LM2	Kali carb LM1	Rhus tox LM1		
	Rhus tox LM1	Rhus tox LM1	Rhus tox LM1	Rhus tox LM2		
	Nat mur LM1	Nat mur LM2	Phosph LM1	Rhus tox LM1	Ars alb LM1	
	Nat mur LM1	Sepia LM1	Sepia LM1	Silica LM1		Nat mur 30
	Nat mur LM1	Silica LM1	Silica LM1	Silica LM2		
	Sepia LM1	Nat mur LM1	Nat mur LM1	Ars Alb LM1		
	Sepia LM1	Sepia LM1	Sepia LM1	Sepia LM1		
	Nux vom LM1	Nux vom LM1	Rhus tox LM1	Rhus tox LM1		
	Kali carb LM1	Kali carb LM1	Kali carb LM1	Kali bich 30		
	Lycopodium LM1	Pulsatilla LM1	Thuja LM1	Sepia LM1		
	Kali carb LM1	Kali carb LM1	Rhus tox LM1	Rhus tox LM1		
	Nat mur LM1	Nat mur LM1	Silica LM1	Nat mur LM1		
	Sulphur LM1	Sulphur LM1	Rhus tox LM1	Rhus tox LM1		
	Staph LM1	Staph LM1	Ars alb LM1	Ars alb LM1		
	Lach LM1	Lach LM1	Lach LM2	Lach LM2		

## **Appendix 12: Common themes and participant experiences**

### COMMON THEMES AND PARTICIPANT EXPERIENCES

#### **Physical presenting symptoms:**

- Joint pain
- Back pain
- Sinusitis
- Headaches
- Lack of energy, inability to do things easily
- Inability to work
- Loss of physical sensation eg smell
- Irritable bowel syndrome
- Asthma
- Allergies
- Diabetes
- Hypertension

#### **Mental/emotional presenting symptoms:**

- Stress
- Anxiety
- Depression
- Grief
- Lack of motivation
- Feeling emotional, crying easily
- Feeling alone
- Irritability
- Anger
- Feeling overwhelmed
- Lack of interest in former pleasure
- Lack of interest in social interaction
- Feeling disconnected from people or work
- Problems with relationships

**Acute illnesses during treatment**

- Dental treatment
- Colds, flu

**Common themes in case histories:**

- Bereavement, longstanding grief
- Loss, disappointment, broken relationships
- Stress at work and/or home
- Conflicting demands or desires
- Significant life events during research participation
- Significant health problems during research participation

**Participant experiences after taking the remedy:**

- No reaction after taking first remedy
- No reaction after taking second remedy
- Aggravation or noticeable symptom within 48 hours of taking remedy
- Change in mood or perception
- Better, then some reversal of improvement
- Improvement identified as associated with the remedy
- Improvement justified by life experience or other therapeutic experience
- Improvement in mood, ability to cope
- Improvement in relationship with others
- Improvement in main physical symptoms
- Improvement in minor physical symptoms
- Improvement in quality of sleep
- Improvement in energy levels and motivation
- Resuming activity which formerly gave pleasure
- Making contact with friends or family

### **Participant knowledge and perception of homeopathy before treatment**

- No knowledge
- Suggested by friend with experience of homeopathy
- Last resort
- Might as well give it a try
- Thought it was something else eg osteopathy, herbal medicine
- Previous use of remedies
- Belief in holistic therapies
- Current role as therapist in other discipline

### **Participant use and view of orthodox medicine**

- Current use of pharmaceutical medicine (range from no drugs to five different types)
- Appointments with GP or specialists during research participation
- Medical tests during research participation
- Major surgery in recent years
- Acceptance of life time use of medication
- Desire to reduce or stop use of medication

## Appendix 13: Unexpected outcomes of homeopathic experience

P	Emotional reaction	Physical outcomes that were unexpected
	Talking so much about herself Crying on the journey home Improved relationship with husband	Elbow got better – not referred to before
	Sadness and tears over past loss	Always constipated on holiday but not after taking remedy
	Crying, feeling down thinking about mother's death	Sneezing for half an hour then pain in wrist stopped.
		Had to use deodorant as some body odour, normally doesn't need it. Hot flushes returned.
	Singing in the bathroom	Spots, rash on face
	Surprised that she talked about... Thought about stress of work, anger	Bloodshot eyes disappeared Sneezing after taking LM2 Hair curls when she's well
		Brown liver spots on hands reduced Healing crisis and felt good afterwards
		At first everything tasted salty Hair curls when she's well
	Aware that she spoke a lot about past	Rash on arms Lost voice
		Already tried this remedy without success so no expectation of it working

## **Appendix 14: Measure Your Own Medical Profile (MYMOP)**



### **Measure Your Own Medical Outcomes Profile**

Confidential questionnaire to be completed by participants in a research study into the use of homeopathy in the 55+ age group

**Thank you for taking part in this study**

Jan Schyma

(Registered Member of the Society of Homeopaths)

24 Ormidale Terrace Edinburgh EH12 6EQ

Telephone: 0131 337 3028 or 0772 070 5271 or visit [www.homeopathyedinburgh.co.uk](http://www.homeopathyedinburgh.co.uk)

## Measure Your Own Medical Outcome Profile

Full name: ..... Date of birth: .....

Address and postcode: .....

.....

Today's date: ..... Practitioner: Jan Schyma

Choose **one** or **two** symptoms (physical or mental) which bother you the most. Write them on the lines. Now consider how bad each symptom is, over the last week, and score it by circling your chosen number.

SYMPTOM 1:	0	1	2	3	4	5	6
.....	As	good	as	it			As
		could be					bad
.....							as it
							could
							be

SYMPTOM 2:	0	1	2	3	4	5	6
.....	As	good	as	it			As
		could be					bad
.....							as it
							could
							be



Now choose **one** activity (physical, social or mental) that is important to you, and that your problem makes difficult or prevents you doing. Score how bad it has been in the last week.

<b>ACTIVITY:</b>	0	1	2	3	4	5	6
.....As good as it							As bad as it
could be							could be
.....							
.							

How would you rate your general feeling of wellbeing during the last week?

	0	1	2	3	4	5	6
As good as it							As bad as it
could be							could be

How long have you had Symptom 1, either all the time, or on and off? Please circle:

0-4 weeks	4-12 weeks	3months- 1 year	1-5 years	Over 5 years
-----------	------------	-----------------	-----------	--------------

Are you taking any medication for this problem? Please circle: **YES / NO**

**IF YES:**

1. Please write in the name of the medication, and how much you take a day or a week:

.....

2. Is cutting down this medication: Please circle:

Not important	A bit important	Very important	Not applicable
---------------	-----------------	----------------	----------------

IF NO:

Is avoiding medication for this problem:

Not important                                      A bit important                      Very important                      Not applicable

## Appendix 15: SF-36 questionnaire

### SF36 Health Survey

**INSTRUCTIONS:** This set of questions asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question please give the best answer you can.

1. In general, would you say your health is: (Please tick **one** box.)

Excellent	<input type="checkbox"/>
Very Good	<input type="checkbox"/>
Good	<input type="checkbox"/>
Fair	<input type="checkbox"/>
Poor	<input type="checkbox"/>

2. Compared to one year ago, how would you rate your health in general now? (Please tick **one** box.)

Much better than one year ago	<input type="checkbox"/>
Somewhat better now than one year ago	<input type="checkbox"/>
About the same as one year ago	<input type="checkbox"/>
Somewhat worse now than one year ago	<input type="checkbox"/>
Much worse now than one year ago	<input type="checkbox"/>

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Please circle **one** number on each line.)

Activities	Yes, Limited A Lot	Yes, Limited A Little	Not Limited At All
3(a) <b>Vigorous activities</b> , such as running, lifting heavy objects, participating in strenuous sports	1	2	3
3(b) <b>Moderate activities</b> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
3(c) Lifting or carrying groceries	1	2	3
3(d) Climbing <b>several</b> flights of stairs	1	2	3
3(e) Climbing <b>one</b> flight of stairs	1	2	3
3(f) Bending, kneeling, or stooping	1	2	3
3(g) Walking <b>more than a mile</b>	1	2	3
3(h) Walking <b>several blocks</b>	1	2	3
3(i) Walking <b>one block</b>	1	2	3
3(j) Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? (Please circle **one** number on each line.)

	Yes	No
4(a) Cut down on the <b>amount of time</b> you spent on work or other activities	1	2
4(b) Accomplished less than you would like	1	2
4(c) Were <b>limited</b> in the <b>kind</b> of work or other activities	1	2
4(d) Had <b>difficulty</b> performing the work or other activities (for example, it took extra effort)	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (e.g. feeling depressed or anxious)? (Please circle **one** number on each line.)

	Yes	No
5(a) Cut down on the <b>amount of time</b> you spent on work or other activities	1	2
5(b) Accomplished less than you would like	1	2
5(c) Didn't do work or other activities as <b>carefully</b> as usual	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups? (Please tick **one** box.)

Not at all ☐  
Slightly ☐  
Moderately ☐  
Quite a bit ☐  
Extremely ☐

7. How much physical pain have you had during the past 4 weeks? (Please tick **one** box.)

None ☐  
Very mild ☐  
Mild ☐  
Moderate ☐  
Severe ☐  
Very Severe ☐

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Please tick **one** box.)

Not at all ☐  
A little bit ☐  
Moderately ☐  
Quite a bit ☐  
Extremely ☐

9. These questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that is closest to the way you have been feeling for each item.

(Please circle one number on each line.)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
9(a) Did you feel full of life?	1	2	3	4	5	6
9(b) Have you been a very nervous person?	1	2	3	4	5	6
9(c) Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
9(d) Have you felt calm and peaceful?	1	2	3	4	5	6
9(e) Did you have a lot of energy?	1	2	3	4	5	6
9(f) Have you felt downhearted and blue?	1	2	3	4	5	6
9(g) Did you feel worn out?	1	2	3	4	5	6
9(h) Have you been a happy person?	1	2	3	4	5	6
9(i) Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives etc.) (Please tick **one** box.)

All of the time ☐  
Most of the time ☐  
Some of the time ☐  
A little of the time ☐  
None of the time ☐

11. How TRUE or FALSE is each of the following statements for you?

(Please circle one number on each line.)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
11(a) I seem to get sick a little easier than other people	1	2	3	4	5
11(b) I am as healthy as anybody I know	1	2	3	4	5
11(c) I expect my health to get worse	1	2	3	4	5
11(d) My health is excellent	1	2	3	4	5

Thank You!

## Appendix 16: An overview of positive homeopathy research

This information about homeopathy research was taken from *An Overview of Positive Homeopathy Research and Surveys*, ENHR (European Network for Homeopathy Researchers) April 2005 compiled by Kate Chatfield and Petter Viksveen. (See Society of Homeopaths (2010) Evidence base for homeopathy <http://www.homeopathy-soh.org/whats-new/research/evid/default.aspx> )

Adler M (1999) Efficacy, safety of a fixed-combination homeopathic therapy for sinusitis *Adv Ther* 1999; 16: 103–111 (Outcomes in an uncontrolled clinical trial: 119 patients suffering from clinical signs of acute sinusitis were treated using homeopathic medicines. Typical sinusitis symptoms, such as headache, pressure pain at nerve exit points, and irritating cough, were reduced after a mean of 4.1 days of treatment. Ninety-nine received only a homeopathic test medication, 20 patients were able to discontinue concomitant medication at the first visit, and only one patient needed antibiotics. Average duration of treatment was 2 weeks. At the end of treatment 81.5 % described themselves as symptom free or significantly improved. No adverse medication effects were reported.)

Attena F et al (2000) Homeopathy in Primary Care: self reported change in health status *Complementary therapies in Medicine* Vol 8 No 1 March 2000 (Outcomes: one year after their first visit to a homeopathic clinic, 609 patients were asked to rate their general health compared with a year ago. 73.5 % reported a marked or moderate improvement in their health status.)

Awdry R (1996) Homeopathy and ME *Journal of Alternative and Complementary Medicine* 1996; February, March, April (Outcomes: A randomised double-blind trial involving 62 patients with ME, reported in some detail, found that 33% of patients in the group receiving homeopathic remedies showed definite improvement compared with none in the placebo group.)

Bell I R, Lewis II D A, Brooks A J, Schwartz G E, Lewis S E, Walsh B T, Baldwin C M (2004) Improved clinical status in fibromyalgia patients treated with individualized homeopathic remedies versus placebo *Int J Neurosci* 2004 (Outcomes: A double-blind, randomised, placebo-controlled trial of individualised homeopathic treatment (LM potency) versus placebo concluded that individualised homeopathy is significantly better than placebo in lessening pain and improving the quality of life and overall health of persons with fibromyalgia.)

Christie E A, Ward Report A T (1993) *Report on a Homoeopathy Project in an NHS Practice* Reprinted February 1997 (Outcomes: British prospective survey of homeopathic treatment of 160 patients, 73% of participants experienced a very positive effect, 27% some effect, and 0% no effect.)

Christie E A, Ward Report A T (1996) *Analysis of effectiveness and cost of homoeopathic treatment within a GP practice at St. Margaret's Surgery, Bradford on Avon, Wilts* ISBN 1 901262 006 (Outcomes: British prospective survey of homeopathic treatment of 223 patients, taking part in an NHS practice-based homoeopathy project. 72% of participants experienced 90% improvement or more, 32% experienced 60% improvement or more, 65% experienced 50% improvement or more.)

Christie E A, Ward A T (1996) Report on NHS practice-based homoeopathy project. *Analysis of effectiveness and cost of homoeopathic treatment within a GP practice at St. Margaret's Surgery, Bradford on Avon, Wilts* September 1996 The Society of Homeopaths ISBN 1 901262 006 (Outcomes: In a survey of 223 patients in an NHS General Practice, the number of consultations with general practitioners was reduced by 70% in a one year period. Expenses for medication were reduced by 50% when homeopathic treatment was made available.)

Dempster A (1998) *Homoeopathy within the NHS Evaluation of homoeopathic treatment of common mental health problems 1995-1997* Rydings Hall Surgery, Brighouse, West Yorkshire ISBN No 1901262014 (Outcomes: British prospective survey of homeopathic treatment of 37 patients suffering from psychological complaints. 81% of participants were very satisfied with outcomes of treatment, 16% were satisfied and 3% were not satisfied.)

Fisher P (1986) An experimental double-blind clinical trial in homoeopathy *British Homoeopathic Journal* 1986; 75: 142-147 (Outcomes: In a randomised placebo-controlled trial of patients with fibrositis, only those patients in whom Rhus toxicodendron was 'unequivocally indicated' were admitted to the study. After one month's treatment, there were highly significant improvements in objective and subjective parameters.)

Frei H, Thurneysen A (2001) Homeopathy in acute otitis media in children: treatment effect or spontaneous resolution? *Br Homeopath J* 2001; 90: 180-182 (Outcomes: In a trial of 230 children who were given homeopathic treatment to treat acute otitis media, pain relief was achieved in 39% of the patients after 6 h and another 33% after 12 h. The resolution rates were 2.4 times faster than in placebo controls. No complications were observed and compared to conventional treatment the homeopathic approach was 14% cheaper.)



Friese K-H, Kruse S, Ludtke R, Moeller H (1997) Homeopathic treatment of otitis media in children: comparisons with conventional therapy *Int J Clin Pharmacol Ther* 1997; 35: 296-301 (Outcomes: in a prospective observational study, comparison of homeopathy versus conventional treatment in acute otitis media. Conclusion: homeopathy should be first line treatment in acute otitis media. Results showed median duration of pain of 2 days in the homeopathy-group and 3 days in the conventional medicine group. 70.7 % of the children receiving homeopathic treatment did not have another ear infection the next year and 29.3 % had a maximum of three ear infections within one year. 56.5 % in the conventional medicine group did not have another ear infection the next year and 43.5 % had a maximum of six ear infections the next year. Results showed that in the group receiving homeopathic treatment only 5 out of 103 children needed antibiotics.)

Gibson R G, Gibson S L M, MacNeill A D, Buchanan W W (1980) Homeopathic therapy in rheumatoid arthritis: evaluation by double-blind clinical therapeutic trial *British Journal of Clinical Pharmacology* 1980; 9: 453-459 (Outcomes: 46 patients with rheumatoid arthritis received an individualised remedy or placebo in a 3-month randomised trial. Both groups were allowed to continue standard anti-inflammatory drugs. After 3 months, the double-blind code was broken and remedies were given to members of the placebo group in a single crossover study. Articular index, limbering up time, grip strength and pain all showed statistically significant differences.)

Güthlin C, Lange O and Walach H (2004) Measuring the effects of acupuncture and homeopathy in general practice: An uncontrolled prospective documentation approach. *BMC Public Health* 2004, 4:6 (Outcomes: a survey of more than 900 patients treated homeopathically showed substantial improvement in quality of life over the first six months after treatment and this effect remained more or less stable over the following years.)

Harrison H, Fixsen A, Vickers A (1999) A randomized comparison of homeopathic, standard care for the treatment of glue ear in children *Compl Therap Med* 1999; 7: 132–135 (Outcomes: In a pilot study in children suffering from glue ear treated with homeopathy 75% had normal tympanogram, compared to 31% in the group treated with conventional medicine. A higher proportion of children receiving homeopathic treatment had a hearing loss less than 20 dB at follow-up, though the difference was not statistically significant. The authors concluded that further research comparing homeopathy to standard care is warranted; 270 patients would be needed for a definitive trial.)

Homeopathic Medicine Research Group (1996) *Report to the European Commission directorate general XII: science, research and development* Vol 1 (short version). Brussels: European Commission, 1996:16-7 (Outcomes: HMRG report with overview of clinical research in homeopathy identified 184 controlled clinical trials and selected the highest quality randomized control trials, which included a total of 2617 patients for a meta-analysis. This meta-analysis resulted in a p-value of 0.000036, which means that results are highly significant, indicating that homeopathy is more effective than placebo.)

Jacobs J (1994) Treatment of acute childhood diarrhea with homeopathic medicine: a randomized clinical trial in Nicaragua *Pediatrics* 1994; 93: 719-725 (Outcomes: Treatment of acute childhood diarrhoea in Nicaragua involving 81 children aged from 6 months to 5 years in a randomised, double-blind trial of intravenous fluids plus placebo versus intravenous fluids plus homeopathic remedy individualised to the patient. The treatment group had a statistically significant decrease in duration of diarrhoea.)

Jacobs J, Jimenez M, Malthouse S, Chapman E, Crothers D, Masuk M, Jonas W B (2000) Acute Childhood Diarrhoea - A Replication *Journal of Alternative and Complementary Medicine*, 6, 2000, 131-139 (Outcomes: Treatment of acute childhood diarrhoea, repeated in Nepal in a replication of a trial carried out in Nicaragua in 1994, 116 Nepalese children aged 6 months to 5 years suffering from diarrhoea were given an individualised homeopathic medicine or placebo. Treatment by homeopathy showed a significant improvement in the condition in comparison to placebo.)

Jacobs J, Springer D A, Crothers D (2001) Homeopathic treatment of acute otitis media in children: a preliminary randomized placebo-controlled trial *Pediatr Infect Dis J* 2001; 20: 177-183 (Outcomes: Acute otitis media study in children involving children suffering from acute otitis media suggests that a positive treatment effect from homeopathy when compared with placebo in acute otitis media cannot be excluded. There were fewer treatment failures in the group receiving homeopathy after 5 days, 2 weeks, and 6 weeks, with differences of 11.4, 18.4, and 19.9%, respectively, but these differences were not statistically significant. Diary scores showed a significant decrease in symptoms at 24 and 64 h after treatment in favour of homeopathy ( $P < 0.05$ ).)

Kim L S, Riedlinger J E, Baldwin C M, Hilli L, Khalsa S V, Messer S A, Waters R F (2005) Treatment of Seasonal Allergic Rhinitis Using Homeopathic Preparation of Common Allergens in the Southwest Region of the US: A Randomized, Controlled Clinical Trial *Ann Pharmacother*. 2005 Apr;39(4):617- 24. Epub 2005 Mar 1. (Outcomes: double-blind clinical trial comparing homeopathic preparations from common allergens (tree, grass, weed) with placebo. 40 patients diagnosed with moderate to severe seasonal allergic rhinitis symptoms were treated over a four week period. Results showed significant positive changes in the homeopathy group compared with the placebo group ( $p < 0.05$ ). No adverse effects were reported.)

Kleijnen J, Knipschild P, Ter Riet G (1991) Clinical trials of homeopathy *British Medical Journal* 1991b;302:316-23 (Outcomes: of the 105 trials with interpretable results, 81 trials indicated positive results, most studies showed results in favour of homeopathy even among those randomized controlled trials that received high quality ratings for randomization, blinding, sample size, and other methodological criteria. They came to the following conclusion: "The amount of positive evidence even among the best studies came as a surprise to us. Based on this evidence we would readily accept that homeopathy can be efficacious, if only the mechanism of action were more plausible. The evidence presented in this review would probably be sufficient for establishing homeopathy as a regular treatment for certain indications".)



Linde K, Jonas WB, Melchart D, Worku F, Wagner H, Eitel F (1994) Critical Review and Meta-Analysis of Serial Agitated Dilutions in Experimental Toxicology *Human and Experimental Toxicology* 1994;13:481-492 (Outcomes: meta-analysis of 105 articles on laboratory research showing a positive effect 50% more frequently than negative effect among trials of highest methodological quality.)

Linde K, Clausius N, Ramirez G, et al (1997) Are the clinical effects of homeopathy placebo effects? A meta-analysis of placebo-controlled trials *Lancet* 1997; 350:834-43 (Outcomes: meta-analysis of 89 trials of homeopathic medicine versus placebo significantly in favour of homeopathy (or 2.45 (95% CI 2.05-2.93)). This meta-analysis included 186 placebo-controlled studies of homeopathy published until mid-1996, of which data for analysis could be extracted from 89. The overall odds ratio was 2.45 (95% confidence intervals 2.05-2.93) in favour of homeopathy, which means that the chances that homeopathy would benefit the patient were 2.45 times greater than placebo. When considering just those trials of high quality published in MEDLINE listed journals, and with predefined primary outcome measures, the pooled odds ratio was 1.97 and significant. Even after correction for publication bias the results remained significant. The main conclusion was that the results "were not compatible with the hypothesis that the effects of homeopathy are completely due to placebo. If the result of new trials were to show no difference between homeopathy and placebo, we would have to add 923 trials with no effect with 118 patients in each in order to balance the two.")

Mathie R. (2003) The research evidence base for homeopathy: a fresh assessment of the literature *Homeopathy* 92: 84-91. 2003 (Outcomes: a systematic review of results from 93 substantive RCTs was carried out by Robert Mathie and concluded that of the 35 different medical conditions covered by these trials the weight of evidence favours a positive treatment effect in 8: childhood diarrhoea, fibrositis, hayfever, influenza, pain (miscellaneous), side-effects of chemotherapy or radiotherapy, sprains and upper-respiratory tract infections.)

Reilly D, Taylor M A, Beattie N G M, Campbell J H, McSharry C, Aitchison T C, Carter R, Stevenson R D (1994) Is evidence for homeopathy reproducible? *Lancet* 1994; 344: 1601-1606 (Outcomes: a meta-analysis of three trials on homeopathic immunotherapy showing significant effects in favour of homeopathic treatment.)

Richardson J. (1996) *Quasi-randomised control trial to assess the outcome of acupuncture, osteopathy and homeopathy using the short form 36 item health survey*. Health Services Research and Evaluation Unit, The Lewisham Hospital NHS Trust. December 1996. (Outcomes for the effect of homeopathy, acupuncture and osteopathy: 89% of patients stated they experienced positive effect from the treatment. Particularly clear effect on reduction of pain, increased vitality, ability to function socially and with regards to limitations at work and in daily activities influenced by physical problems. Homeopathy was particularly effective for patients suffering from arthritis, hayfever, atopic asthma and skin complaints.)

Reilly D T, Taylor M A, McSharry C, Aitchison T (1986) Is homoeopathy a placebo response? Controlled trial of homoeopathic potency, with pollen in hay fever as a model *Lancet* 1986; ii: 881-886

Reilly D T, Taylor M A, Campbell J, Beattie N, McSharry C, Aitchison T, Carter R, Stevenson R (1994) Is evidence for homoeopathy reproducible? *Lancet* 1994; 334: 1601-1606 (Outcomes: Reilly and colleagues have conducted a series of trials in patients with hayfever, asthma and perennial rhinitis. Patients were given skin tests and remedies were chosen on the basis of reactivity. This design allows individualisation whilst avoiding the issues of case-taking and the effect that this has on the process. The results demonstrate a significant difference between the placebo and homeopathic groups which is reproducible. This approach is referred to as isopathy.)

Relton C (2009) *NHS Homeopathy Menopause Service Outcome Study* in press (Outcomes: in a prospective study 82 % of 102 patients reported improvement of menopause symptoms after homeopathic treatment. Main symptoms noted were hot flushes and sweats, tiredness, anxiety, sleeping difficulties, mood swings and headaches. Women referred for homeopathy were those who either could not take hormone replacement treatment (HRT), for whom HRT was unsuccessful, who did not want or who had to come off HRT. Mean length of homeopathic treatment was 5 months.)

Riley D, Fischer M, Singh B, Haidvogel M, Heger M (2001) Homeopathy and conventional medicine: an outcomes study comparing effectiveness in a primary care setting *J Altern Complement Med* 2001; 7:149-159 (Outcomes for homeopathy versus conventional treatment in respiratory tract complaints: in an outcome study, 30 practitioners in four countries enrolled 500 consecutive patients with at least one of three complaints: upper respiratory tract complaints including allergies; lower respiratory tract complaints including allergies; or ear complaints. Of 456 patients, 281 received homeopathy and 175 conventional treatment. The primary outcomes criterion was response to treatment, defined as cured or major improvement after 14 days of treatment. Results showed a response rate of 82.6% in the homeopathy group compared to 67.3% in the group receiving conventional medicine. The authors concluded that homeopathy appeared to be at least as effective as conventional treatment of patients with the three conditions studied.)

Sevar R (2000) Audit of outcome in 829 consecutive patients treated with homeopathic medicine *British Homeopathic Journal* Vol 89 No 4 Oct 2000 (Outcomes: a study of 829 patients treated with homeopathic medicines, where conventional treatment had been unsatisfactory or contraindicated, found that 61 % had a substantial improvement with homeopathy.)

Shealy C N, Thomlinson P R, Cox R H, Bormeyer V (1998) Osteoarthritis Pain: A Comparison of Homoeopathy and Acetaminophen *American Journal of Pain Management* 8, 3, July 1998, 89-91 (Outcomes: 65 sufferers of osteoarthritis (OA) were split into two groups, and through a double blinding process were given either a homoeopathic medicine or Acetaminophen, a commonly prescribed drug for pain relief in OA. Researchers found that homoeopathy provided a level of pain relief that was superior to Acetaminophen and produced no adverse reactions.)

Steinsbekk A (2005) Patients' assessments of the effectiveness of homeopathic care in Norway: A prospective observational multicentre outcome study *Homeopathy* Volume 94, Issue 1, January 2005, Pages 10-16 (Outcomes: 7 out of 10 patients visiting Norwegian homeopaths reported a meaningful improvement in their main complaint six months after the initial consultation.)

Swayne J (1992) The cost, effectiveness of homoeopathy A pilot study, proposals for future research *Br Homoeopath J* 1992; 81: 148–150 (Outcomes: a study of the cost and effectiveness of homeopathy suggested that doctors practising homeopathy issue fewer prescriptions and at a lower cost than their colleagues. The main costs for homeopathic treatment are for consultations with each individual patient. Costs for the actual medications used are relatively low, particularly when compared with conventional drugs.)

Thompson E A, Reilly D (2003) The homeopathic approach to the treatment of symptoms of oestrogen withdrawal in breast cancer patients. A prospective observational study *Homeopathy* 2003 Jul;92(3):131-4 (Outcomes: 40 out of 45 women with breast cancer withdrawing from oestrogen and then treated homeopathically, experienced significant improvement in their primary symptoms, anxiety and depression, as well as improvement in quality of life. Primary symptoms changed from 7.8 to 5.4, and from 7.2 to 4.1 ( $p < 0.001$ ). The homeopathic approach appears to be clinically useful in the management of oestrogen withdrawal symptoms in women with breast cancer.)

Trichard M, Chaufferin G, Nicoloyannis N (2005) Pharmacoeconomic comparison between homeopathic and antibiotic treatment strategies in recurrent acute rhinopharyngitis in children *Homeopathy* 2005 Jan; 94(1):3-9 (Outcomes: homeopathy versus conventional treatment in recurrent acute rhinopharyngitis in children in a prospective pragmatic study, comparison of homeopathy versus antibiotics in the treatment of recurrent acute rhinopharyngitis in children (18 months to 4 years) over a 6 month period. Results showed that homeopathy was significantly better than antibiotics in terms of episodes of rhinopharyngitis (2.71 vs 3.97,  $p < 0.001$ ), number of complications (1.25 vs 1.95,  $p < 0.001$ ) and quality of life (global score: 21.38 vs 30.43,  $p < 0.001$ ). Homeopathic treatment also contributed to lower medical costs (88 Euros vs 99 Euros,  $p < 0.05$ ) and significantly less sick-leave (9.5% of parents vs 31.6% of parents,  $p < 0.001$ .)

Yakir M, Kreitler S, Brzezinski A, Vithoulkas G, Oberbaum M, Bentwich Z (2001) Effects of homeopathic treatment in women with premenstrual syndrome: a pilot study. *Br Homeopath J* 2001 Jul ;90(3): 148-53 (Outcomes: in a randomized controlled double-blind clinical trial (1992-94) 19 women suffering from PMS were treated individually with homeopathy. 90 % of the patients who had received homeopathic treatment experienced more than 30 % improvement. Only 37.5 % of patients who received placebo experienced a similar improvement. Sick-days taken before menses were reduced from 0.75 to 0 in the homeopathy group and was unchanged in the control group. Use of conventional drugs was also reduced in the homeopathy group.)

## Appendix 17: Examples of Crosstabulation and Chi-Square tests for SF-36 data

All SF-36 data was analysed using crosstabulation and Chi-Square tests. Examples of the results for the study cohort for some of the questions are presented here.

1. In general, would you say your health is:

		Q1A1 * Q1A4 Crosstabulation					
Count							
		Q1A4					
		excellent	very good	good	fair	poor	Total
Q1A1	very good	2	8	0	0	0	10
	good	0	1	6	0	0	7
	fair	0	1	0	0	0	1
	poor	0	0	0	1	1	2
	Total	2	10	6	1	1	20

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	36.229 <sup>a</sup>	12	.000
Likelihood Ratio	30.982	12	.002
Linear-by-Linear Association	12.824	1	.000
N of Valid Cases	20		

a. 19 cells (95.0%) have expected count less than 5. The minimum expected count is .05.

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

3(d) Climbing **several** flights of stairs

**Q3dA1 \* Q3dA4 Crosstabulation**

Count					
		Q3dA4			
		limited a lot	limited a little	not limited at all	Total
Q3dA1	limited a lot	1	3	0	4
	limited a little	0	2	4	6
	not limited at all	0	0	10	10
	Total	1	5	14	20

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	14.762 <sup>a</sup>	4	.005
Likelihood Ratio	17.704	4	.001
Linear-by-Linear Association	11.986	1	.001
N of Valid Cases	20		

a. 8 cells (88.9%) have expected count less than 5. The minimum expected count is .20.

### 3(f) Bending, kneeling, or stooping

**Q3fA1 \* Q3fA4 Crosstabulation**

Count					
		Q3fA4			
		limited a lot	limited a little	not limited at all	Total
Q3fA1	limited a lot	1	1	0	2
	limited a little	0	5	3	8
	not limited at all	0	2	8	10
	Total	1	8	11	20

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	13.744 <sup>a</sup>	4	.008
Likelihood Ratio	10.439	4	.034
Linear-by-Linear Association	7.711	1	.005
N of Valid Cases	20		

a. 8 cells (88.9%) have expected count less than 5. The minimum expected count is .10.

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours or groups?

**Q6A1 \* Q6A4 Crosstabulation**

Count						
		Q6A4				
		not at all	slightly	moderately	quite a bit	Total
Q6A1	not at all	3	3	0	1	7
	slightly	3	4	1	0	8
	moderately	2	0	1	0	3
	quite a bit	1	0	0	0	1
	extremely	0	1	0	0	1
	Total	9	8	2	1	20

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.697 <sup>a</sup>	12	.729
Likelihood Ratio	10.768	12	.549
Linear-by-Linear Association	.184	1	.668
N of Valid Cases	20		

a. 20 cells (100.0%) have expected count less than 5. The minimum expected count is .05.



7. How much physical pain have you had during the past 4 weeks?

		Q7A1 * Q7A4 Crosstabulation					
Count							
		Q7A4					
		none	very mild	mild	moderate	severe	Total
Q7A1	none	0	2	0	0	0	2
	very mild	0	3	0	0	0	3
	mild	1	5	0	1	0	7
	moderate	1	2	3	0	1	7
	very severe	0	0	0	1	0	1
	Total	2	12	3	2	1	20

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	20.952 <sup>a</sup>	16	.180
Likelihood Ratio	19.028	16	.267
Linear-by-Linear Association	3.656	1	.056
N of Valid Cases	20		

a. 25 cells (100.0%) have expected count less than 5. The minimum expected count is .05.

9. These questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that is closest to the way you have been feeling for each item.

9(e) Did you have a lot of energy?

**Q9eA1 \* Q9eA4 Crosstabulation**

Count								
		Q9eA4						
		all	most	good bit	some	little	none	Total
Q9eA1	most	1	3	0	0	0	0	4
	good bit	0	2	1	2	0	1	6
	some	0	2	1	2	0	0	5
	little	0	0	0	2	0	0	2
	none	0	1	0	0	1	1	3
	Total	1	8	2	6	1	2	20

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	22.014 <sup>a</sup>	20	.340
Likelihood Ratio	21.916	20	.345
Linear-by-Linear Association	4.694	1	.030
N of Valid Cases	20		

a. 30 cells (100.0%) have expected count less than 5. The minimum expected count is .10.